Iowa

UNIFORM APPLICATION
FY 2020/2021 Community Mental Health Services Block Grant Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/30/2019 5.29.20 PM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

State DUNS Number

Number 137348624

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name Iowa Department of Human Services

Organizational Unit Division of Mental Health and Disability Services

Mailing Address 1305 E. Walnut

City Des Moines

Zip Code 50319

II. Contact Person for the Grantee of the Block Grant

First Name Richard

Last Name Shults

Agency Name Iowa Department of Human Services

Mailing Address 1305 E. Walnut

City Des Moines

Zip Code 50319

Telephone 515-281-8580

Fax

Email Address rshults@dhs.state.ia.us

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date	8/30/2019 5:28:31 PM
Revision Date	

VI. Contact Person Responsible for Application Submission

First Name	Laura
Last Name	Larkin
Telephone	5152425880
Fax	
Email Address	llarkin@dhs.state.ia.us

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Gerd W. Clabaugh. MPA

Signature of CEO or Designee[1]: _____

Title: Interim Director, Department of Human Services Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

June 26, 2019

Substance Abuse and Mental Health Services Administration
Office of Financial Resources, Division of Grants Management
5600 Fishers Lane, 17th Floor
Rockville, MD 20850

To Whom It May Concern:

This letter designates Gerd W. Clabaugh, Interim Director of the Iowa Department of Human Services, to function as my designee for the following Substance Abuse and Mental Health Services Administration (SAMHSA) programs for as long as I remain Governor of the State of Iowa and Mr. Clabaugh remains Interim Director of the Iowa Department of Human Services.

1. Gerd W. Clabaugh is authorized to function as my designee for all activities related to the SAMHSA Projects in Assistance in Transition from Homelessness (PATH) program.

2. Gerd W. Clabaugh is authorized to function as my designee for all activities related to the SAMHSA Community Mental Health Block Grant (MHBG) program.

Please contact my office if you have any questions.

Sincerely,

Kim Reynolds
Governor of Iowa

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Gerd W. Clabaugh, MPA

Signature of CEO or Designee[1]:

Title: Interim Director, Department of Human Services

Date Signed: August 29, 2019
mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Step 1-Address the strengths and organizational capacity of the service system to address the specific populations

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services.
The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

Table of Contents:

I. THE STATE MENTAL HEALTH AUTHORITY

The Iowa Department of Human Services (DHS), Division of Mental Health and Disability Services (MHDS) is the designated State Mental Health Authority (SMHA) for Iowa. Rick Shults is the Division Administrator for MHDS.

The division provides leadership and sets the direction of state policy for the system of mental health and disability services in Iowa. MHDS plans for and oversees the provision of disability-related services for children and adults with a wide range of disability conditions, including mental illness, serious emotional disturbance, intellectual disabilities, developmental disabilities, and brain injury. The division distributes and oversees the use of federal and state funding through contracts with providers or other agencies that offer services or coordinate projects that promote the division's goals. This includes oversight and distribution of federal funds received through the Community Mental Health Block Grant (MHBG) and the Projects for Assistance in Transition from Homelessness (PATH) grant.

MHDS works with service providers to assure quality by setting standards for certain facilities and services that are provided to adults and children with mental illness, intellectual disabilities, developmental disabilities and brain injury and evaluating how well those standards are met through an accreditation process.

MHDS staff meet with regional CEOs on a monthly basis to ensure communication across the system regarding policy issues, service delivery and coverage, and coordination with other entities such as the MCOs and public health. MHDS works with the Regions on an annual basis to approve their annual service and budget plans. All amendments to Regional policy and procedure manuals must be approved by the Department. Two MHDS staff provide technical assistance and consultation to the regions both in the field or via phone or email as needed. The type of assistance varies from region to region as they continue to expand the array of services provided and the use of evidence-based practices (EBPs).

MHDS works collaboratively with other DHS divisions including the Iowa Medicaid Enterprise (IME) and Adult, Child and Family Services (Child Welfare) to coordinate mental health policy and reimbursement and implement mental health services.

The division houses the state disaster behavioral health coordinator and oversees and implements FEMA crisis counseling programs for persons affected by disasters as well as a volunteer Disaster Behavioral Health Response Team that can deploy quickly to assist with immediate behavioral health needs during a disaster or other traumatic event.

The division works collaboratively with other state agencies to promote integrated employment options for individuals with disabilities, including mental illness.

MHDS provides staffing and coordination to the state Mental Health and Disability Services Commission and the Mental Health Planning Council.

When directed by legislation, MHDS organized and facilitates workgroups designed to address mental health system gaps and barriers. The most recent workgroup was focused on

development of a children's behavioral health system and the outcomes of that workgroup will be covered later in the document. Workgroups are typically comprised of other state agency staff, advocates, stakeholders, service providers, Iowans with lived experience and their family members, and family members of children with a serious emotional disturbance (SED).

MHDS includes:

- The Bureau of Community Services and Planning (provides oversight of the MHBG)
- The Bureau of Targeted Case Management
- The Civil Commitment Unit for Sexual Offenders (violent sexual predators)
- The two State Resource Centers for individuals with developmental and intellectual disabilities.
    - Woodward State Resource Center
    - Glenwood State Resource Center
- The Office of Facility Support
- The two state Mental Health Institutes which provide inpatient mental health services to adults and children.
    - Cherokee Mental Health Institute
    - Independence Mental Health Institute
- Eldora State Training School-for juvenile males adjudicated delinquent

II. ORGANIZATION OF THE PUBLIC MENTAL HEALTH SYSTEM FOR CHILDREN AND ADULTS

The Iowa system of mental health services for adults and children with mental illness is managed and funded in various ways depending on an individual's income, insurance coverage, and service needs. This section addresses state agencies' responsibilities for mental health services. Services specifically for children will be identified throughout this section.

A. IOWA DEPARTMENT OF HUMAN SERVICES- MHDS, IME, and ACFS

MHDS:

The role of MHDS in the public mental health system is described in Section I. The State Mental Health Authority

Medicaid

Medicaid is a primary funder of mental health services for Iowans. Medicaid is projected to serve nearly 783,000 Iowans or 24.9% of Iowa's population in SFY20. Effective January 1, 2014, Iowa expanded Medicaid through the Iowa Health and Wellness Plan (IHWP) for individuals ages 19-64 with income at or below 133% of the Federal Poverty Level without regard to categorical eligibility. IHWP-eligible individuals receive a limited set of mental health services. Individuals eligible for IHWP coverage and deemed "medically exempt", which includes individuals with chronic mental illness, chronic substance use disorders, and other serious medical conditions may choose between IHWP or state plan Medicaid. Access to state plan Medicaid allows the individual to receive HCBS services, integrated health home care coordination, and other community-based supports not available under the IHWP plans. Access to state-plan Medicaid for the IHWP-eligible population has increased access to services for individuals with serious mental health conditions.

The Department implemented the IA Health Link managed care program for the majority of the Medicaid and Hawki (the State Children's Health Insurance Program) population on April 1, 2016. Most Medicaid members are now being served by two managed care organizations (MCOs); Amerigroup and Iowa Total Care. The Iowa Medicaid Enterprise (IME) continues to operate a limited Fee-For-Service (FSS) program for the Medicaid members not enrolled in managed care. DHS has contracted with MCOs to provide comprehensive health care services including physical health, pharmacy, behavioral health, and long term supports and services. This single system of care promotes the delivery of efficient, coordinated and high quality health care and established accountability in health care coordination.

Effective July 1, 2019, the IME implemented passive assignment for Medicaid enrollees. Once a member has been deemed eligible for Medicaid, they will be automatically assigned to a MCO. Members will be able to receive services from this MCO immediately. Members will have 90 days from their initial enrollment to change MCOs for any reason. If they don't make a choice, they will remain with the MCO assigned to them until their open choice period or can show good cause to switch MCOs. This will result in a decrease in the number of Fee-for-Service enrollees.

Adult, Child, and Family Services- ACFS

ACFS administers adoption subsidies for families who adopt children with special needs. Special needs can include mental health needs. The subsidy can include financial payments to help meet the child's needs and provides eligibility to Medicaid. ACFS also provides child welfare services to families and children who are either at risk for abuse or have experienced abuse and been adjudicated a child in need of assistance. These services can include mental health treatment and supports if needed. Children in foster care are eligible for Medicaid and can access the full array of Medicaid-funded mental health services. Services are also provided to youth aging out of the foster care system to assist in a successful transition to adulthood.

DHS is poised to Implement the Family First Act, affecting child welfare and foster care programs starting July 1, 2020. The Family First Act was signed by President Trump February 9, 2019 and changes the way state child welfare agencies are able to administer foster care programs. Federal foster care funding, included in provisions of the Social Security Act Chapter IV-E, has always been for reimbursement of foster care services, including licensed foster families and residential facilities. As soon as the law is implemented in Iowa in 2020, DHS can not only continue to draw federal funds for certain "stranger" foster care placements, but IV-E funds will also be allowed for services to keep children at home with their parents or with relatives. This means that DHS can draw federal funds to pay for evidence-based family services; services proven to keep children safely with the parent. Specifically, IV-E dollars can be used to purchase high quality mental health, substance abuse and parenting skills training services for the family.

B. IOWA DEPARTMENT OF EDUCATION

The Iowa Department of Education (DE) works collaboratively with DHS to support mental health services for children. The director of the DE is the co-chair, along with the director of DHS, of the new Children's Behavioral System State Board. The involvement of the DE with the development of the children's behavioral system will inform stakeholders of the effect of

children's mental health needs on the education system and encourage cross-system integration of services and supports for children. In 2018, legislation was passed that required all public school districts to provide one hour of school employee training regarding suicide prevention and postvention, identification of adverse childhood experiences and strategies to mitigate toxic stress response. The DE has also implemented the Project AWARE grant which has built capacity for mental health training of school staff and development of school-based mental health services.

C. IOWA DEPARTMENT OF PUBLIC HEALTH (IDPH)

IDPH is the Single State Authority (SSA) for comprehensive primary prevention, treatment and recovery services related to substance use disorders. Overall, the SSA is responsible for comprehensive statewide planning, coordination, delivery, monitoring and evaluation of substance abuse prevention services including: collaboration at local, state and national levels on prevention initiatives and policy; community-based activities, coalitions, and programs; data management and reporting; evidence-based curricula and models; prevention practitioner training and workforce development; public and professional information and education and the single statewide resource and helpline at: www.yourlifeiowa.org.

The SSA oversees the Substance Abuse Prevention and Treatment Block Grant and associated State appropriations for SUD prevention and treatment services. IDPH also is the licensing authority for licensed behavioral health professionals and substance use disorder treatment providers. IDPH licensed providers work in both mental health and substance use disorder provider locations. MHDS and IDPH work collaboratively on projects of joint significance including development of a 24 hour mental health crisis line (Your Life Iowa) integrated into the framework developed by IDPH for SUD crisis and referral and suicide prevention.

A responsibility of the Bureau of Substance Abuse is to manage the Integrated Provider Network (IPN). The IPN is a competitively procured statewide network of prevention and treatment providers, that offer substance use and problem gambling education, prevention, early intervention, treatment, and recovery support services statewide to individuals at or below 200% of the Federal Poverty Level guidelines. Integrated Provider Network services are funded by the State General Fund appropriation to IDPH for substance abuse and problem gambling services under the Addictive Disorders appropriation, and through the SAMHSA Substance Abuse Prevention and Treatment Block Grant (SABG). Integrated Provider Network contractors were selected in 2018 through a competitive Request for Proposals process and began providing services January 1, 2019.

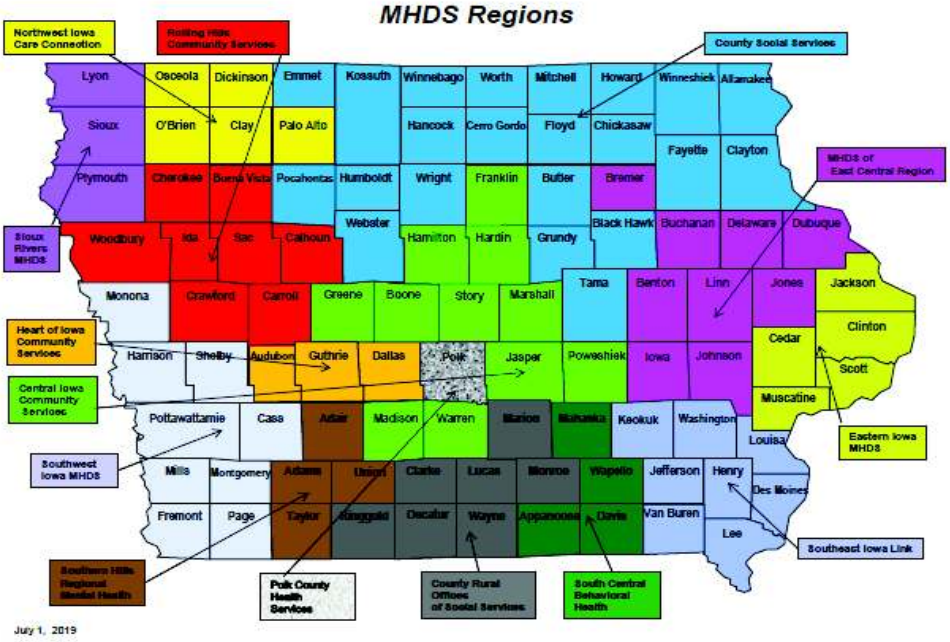
IDPH also provides prevention and early identification services through home-visiting, maternal and child health programs, and programs to develop early childhood mental health consultation capacity.

D. MHDS REGIONAL SERVICES AND FUNDING FOR ADULTS AND CHILDREN

In 2015, Iowa transitioned from a county-based system to a regional system for mental health and disability services. Services are required to be regionally managed and locally available, in compliance with statewide standards. Changes from the previous county-based system included the provision of standardized core services with defined access standards.

Under the regional MHDS system, regions of at least three counties provide services under a regional administrative entity with local access points available to individuals within the region. One county received a waiver to form a region of one county, while the remaining 13 regions are comprised of groups of 3 to 22 counties. With regionalization, counties are able to pool local tax dollars to deliver required core services and evidence-based practices as well as implement additional core services and share administrative responsibilities.

Iowa's 14 MHDS regions, through property tax dollars raised by the counties, are required to provide access to a set of core services that include outpatient mental health services, inpatient mental health (and services associated with involuntary hospitalizations), basic crisis response, support for community living, support for employment, and service coordination for eligible residents of the region. Regions are responsible for funding those services for residents that meet financial guidelines when no other funding is available through Medicaid or private insurance



In 2018, as a result of legislation mandating development of services for individuals with complex mental health and disability needs, additional core services were added to the regions' requirements.

These new core services include:

- Access centers for persons experiencing a mental health or SUD crisis
- Assertive Community Treatment,
- Crisis stabilization services-community and residential
- Intensive residential service homes.
- Mobile crisis response
- Subacute mental health services

- 23-hour crisis observation and holding

Regions are required to provide access to the new core services by July 1, 2021 and are in the process of developing these services.

Regions are also developing and funding additional core services such as civil commitment pre-screening, and jail diversion when funds are available. Regions are also supporting development of crisis services using telehealth in rural areas where mental health professionals may not be available. The regions, the MCOs, and DHS are working collaboratively to ensure that all services that are Medicaid-reimbursable are billed, preserving regional funding for services and individuals not covered by Medicaid.

In 2019, as a result of the passage of HF 690, the development of a children's behavioral health service system was added to the regions' responsibilities. Most of the children's services will be funded by Medicaid and other private insurance. Regions will be required to fund a set of core services for children with a serious emotional disturbance (SED) whose families meet the financial guidelines of income between 150-500% of federal poverty level. Core services for children with an SED include:

- Assessment and evaluation relating to eligibility for services
- Prevention; early identification; early intervention; and education services
- Medication prescribing and management
- Behavioral health outpatient therapy
- Comprehensive facility and community-based crisis services to include:
    - behavioral health inpatient treatment
    - crisis stabilization, community-based and residential services.
    - mobile response
    - Crisis services are available regardless of a diagnosis of a serious emotional disturbance

MHDS, in consultation with the MHDS Commission and the Children's State Board, is in the process of promulgating administrative rules to implement the requirements of House File 690. The rules will define the core services, provider standards, access standards, and implementation dates.

E. LEGISLATION AFFECTING THE PUBLIC MENTAL HEALTH SYSTEM

Complex Needs Legislation-SF 504 and HF 2456

2017 Iowa Acts Chapter 109 (SF504) established a stakeholder workgroup to make recommendations related to the delivery of, access to, and coordination and continuity of mental health, disability, and substance use disorder services for individuals with complex service needs. The Complex Service Needs Workgroup recommendations can be found at: https://dhs.iowa.gov/sites/default/files/ComplexServiceNeeds_WorkgroupReport.pdf

As a result of the workgroup's recommendations, House File 2456 was signed into law on March 29, 2018. This legislation requires access to an expanded array of mental health and substance use disorder services and supports for individuals with the most complex service needs. It

requires MHDS Regions to establish, implement and maintain the new core services. These core services include access centers, assertive community treatment, a full array of mental health crisis response and sub-acute services, and intensive residential service homes.

HF 2456 also established workgroups to review the mental health and substance use disorder commitment processes and the role of tertiary care psychiatric hospitals.

Information regarding the Complex Service Needs Workgroup, Commitment Process Workgroup, and Tertiary Care Psychiatric Hospital Workgroup can be found at: http://dhs.iowa.gov/mhds/community-integration

Children's System Legislation-Governor's Executive Order and House File 690

In 2018, Governor Reynolds signed an Executive Order establishing a Children's System State Board to development a strategic plan for development and implementation of the children's mental health system. The board was tasked with submitting a strategic plan to the Governor and general assembly by Nov. 15, 2018. This report recommended an array of services to include prevention, early identification, crisis, behavioral health treatment, and community-based flexible supports. The report recommended that MHDS regions be designated the point of responsibility to develop the core services, funding should be identified to support the system, and that administrative rules be developed. The report is located here: https://dhs.iowa.gov/about/mhds-advisory-groups/childrens-system-state-board/executive-order-2-board

As a result of the recommendations of the Children's System State Board and the advocacy of family members, stakeholders and other supporters of children's mental health, HF 690 was passed and signed into law on May 1, 2019. This law established the children's behavioral system state board, replacing the children's board created by Executive Order. The Children's Behavioral Health System State Board (Children's Board) is the single point of responsibility in the implementation and management of a Children's Mental Health System (Children's System) that is committed to improving children's well-being, building healthy and resilient children, providing for educational growth, and coordinating medical and mental health care for those in need.

The Children's Board consists of 17 voting members appointed by the Governor. The Children's Board is co-chaired by the Department of Human Services and Department of Education. Members of the Children's Board were selected based on their interest and experience in the areas of children's mental health, education, juvenile court, child welfare, or other related fields.

HF 690 also identified the target population, core services, and responsibilities of the MHDS regions in the development of the Children's Behavioral Health System. More information about the Children's Board is located here: https://dhs.iowa.gov/about/mhds-advisory-groups/childrens-system-state-board

F. OLMSTEAD PLAN FOR MENTAL HEALTH AND DISABILITY SERVICES 2016-2020

The Olmstead Plan for Mental Health and Disability Services (2016-2020) was adopted by the DHS Council on Human Services in October 2017. The five-year plan, which was developed in collaboration with stakeholders beginning in 2016, is designed to continue moving Iowa's mental health and disability services system closer to the vision of "life in the community for everyone."

In developing the plan, the Department worked with a committee of the Olmstead Consumer Task Force, and continues to consult with the Iowa Mental Health and Disability Services Commission, the Iowa Mental Health Planning and Advisory Council, and the Iowa Developmental Disabilities Council, as well as other stakeholders, including individuals with mental illness or other disabilities, family members, advocates, service providers, and representatives of state agencies and county governments.

The plan is built on recent systems and policy changes and is designed to be flexible in responding to new challenges and opportunities and to enable tracking and reporting on measurable person-centered outcomes that reflect community capacity, choice, and self-determination. The plan framework is designed to achieve measurable progress toward target outcomes in nine domains: access to services, community integration, employment, housing, transportation, person-centeredness, health and wellness, quality of life and safety, and family and natural supports.

•Individuals with disabilities and mental illnesses have timely and convenient access to services and supports that are responsive to their needs and preferences, and are provided by a qualified, well-trained, and supported workforce.
•Individuals with disabilities and mental illnesses are valued, respected, and active members of their communities.
•Children with disabilities and mental health conditions are appropriately educated in integrated settings. Adults with disabilities and mental illnesses are employed in integrated settings of their choice, earning competitive wages and benefits. Older adults with disabilities and mental illnesses engage in meaningful activities of their choice.
•Individuals with disabilities and mental illnesses live in integrated settings of their choice that are safe, decent, affordable, and accessible.
•Individuals with disabilities and mental illnesses have adequate transportation to get to the places they need and want to go.
•Individuals with disabilities and mental illnesses are supported and empowered to make informed choices about their personal goals, daily activities, individualized service plans, and civic involvement.
•Individuals with disabilities and mental illnesses receive quality health care and are supported in living healthy lives.
•Individuals with disabilities and mental illnesses are safe, free from all forms of neglect and mistreatment, and are empowered to improve their quality of life.
•Individuals with disabilities and mental illnesses are supported by family members and friends of their choice, and have social connections within their communities.

Statistical data related to performance measures and personal experience survey responses from individuals utilizing publicly funded services are tracked and reported on a quarterly or annual

basis by the Iowa Medicaid Enterprise, Iowa's Medicaid Managed Care Organizations, the Iowa MHDS Regions, the Iowa Department of Education, and others. The information collected is reviewed at least annually and compiled to create "snapshots in time" updates on Iowa's progress toward the Olmstead Plan goals.

G. PEER-RUN SERVICES/ CONSUMER ADVOCACY ORGANIZATIONS

Access for Special Kids (ASK) Family Resource Center is a "one-stop-shop" for children and adults with disabilities and their families. ASK Resource Center provides a broad range of information, advocacy, support, training, and direct services. Access for Special Kids identifies its primary focus as offering information and resources for the benefit of children with disabilities and their families throughout the state of Iowa. ASK also operates the Parent Training and Information (PTI) Center of Iowa. PTI is a federally funded grant project from the U.S. Department of Education that focuses on the educational needs of children with disabilities in Iowa, particularly those who are underserved or may be inappropriately identified. In addition to technical assistance to families, PTI also provides training on the Individuals with Disabilities Education Act (IDEA). The goal is to help parents better understand the Individual Education Program (IEP) and Individual Family Support Program (IFSP) process and become better advocates for their children. There is no cost for information and training provided to families. Shared costs may be requested for services to professionals and others. Services provided include information and training on IDEA, skills to effectively participate in the IEP process, communication strategies to help improve family/ school relationships, information on family support, disability types and rights.

Life Connections Peer Recovery Services

Life Connections Peer Recovery Services is a non-for-profit organization that supports individuals who are experiencing Mental Health and Substance addiction issues and who want to work on their recovery goals and situations before getting into a crisis situation. Life Connections operates a wellness recovery center and a peer-run respite center. Wellness recovery action planning (WRAP) is offered through the wellness recovery Center.

National Alliance on Mental Illness (NAMI) is a 501c3 non-profit organization offering support, education, and advocacy to persons, families, and communities affected by mental illness. The NAMI organization operates at the local, state and national levels and is the largest grassroots organization of its kind working on mental illness issues.

Besides the state office, Iowa has 13 local affiliates and 3 support group organizations. Each local affiliate offers a variety of educational activities and support groups for consumers, family members, and parents/caregivers of children and adolescents with severe emotional disorder. Local affiliates and the state organization identify and work on issues most important to their community and state. The goal is to free people with mental illnesses and their families from stigma and discrimination, and to assure their access to a world-class mental health treatment system to speed their recovery.

The Office of Consumer Affairs (OCA)

OCA is supported by the Mental Health Block Grant and offers a variety of services and supports to persons and families with behavioral health recovery and disabilities challenges, other state agencies and providers.

The Office of Consumer Affairs:

- Serves as a statewide resource for information, referrals, community education, individual education, one-on-one problem solving, and system navigation.
- Provides input on the development and implementation of policies and programs impacting behavioral health services and systems in Iowa.
- Provides an advocacy voice to stakeholder groups throughout the state with the goal of promoting awareness of the concerns, perspectives and vision of persons and families with behavioral health recovery and disabilities challenges.
- Assists DHS staff and contractors with disseminating information and gathering feedback from end users of behavioral health services and systems in Iowa.

The Office of Consumer Affairs Director and a statewide Advisory Committee function to represent Iowans across the state.
https://namiiowa.org/iowa-office-consumer-affairs/

Please Pass the Love
Please Pass the Love (PPTL) is an organization committed to increasing school-based mental health supports to improve the quality of life and educational opportunities for children, families, and educators as well as offer culturally responsive comprehensive services and evidence-based supports to school systems. The organization works to bridge positive relationships between the educational and mental health communities to more effectively prevent and address mental health issues for children and adolescents throughout the state of Iowa. PPTL offered its 7th annual Iowa School Mental Health Conference in August 2019.

Plugged-In Iowa
Plugged –In Iowa provides mental health peer support services to people in need of finding resources and services, of extra support, and want to begin their journey towards recovery. The agency believes that your mental health diagnosis doesn't dictate who you are or what you can do.

Plugged-In Iowa believes that everyone deserves a better quality of life and sometimes need a little extra help and encouragement in order to achieve that. Peer support involves connecting an individual with assistance from someone with lived experience, someone who has been where they are and has found recovery. Peer support is an evidenced based practice and is becoming a vital part of treatment for many people all over the world.

Support includes providing an atmosphere in which an individual's recovery is supported through the use of one-to-one intentional peer support, peer recovery zones, and crisis respite care.

III. THE CONTINUUM OF SERVICES

A. PREVENTION

Education for the general public and providers

Iowa offers a wide variety of training opportunities related to mental health. The focus on professional growth and development is a strength of the Iowa mental health and disability system. Individuals with lived experience and their families are integral participants of many of the training opportunities offered, either as attendees, planners, or presenters. Education on mental health conditions is essential to reduce stigma and increase public awareness of mental health conditions and appropriate interventions, as well as to improve quality and capacity of the mental health provider community. The MHDS regions are also strong supporters of community education with several regions supporting Mental Health First Aid and Youth Mental Health First Aid trainings for their communities and training in evidence-based practices

Adverse Childhood Experiences (ACEs)

The Central Iowa Adverse Childhood Experience (ACEs) 360 Steering Committee makes online training available regarding the impact of adverse childhood experiences and trauma on children's current and future development, behaviors, and long-term health outcomes. Also available through the website is Iowa-specific data regarding ACES, trauma-informed services, and information on statewide activities related to awareness of the effects of ACES on children and adults. The website is: http://www.iowaaces360.org/

Mental Health First Aid and Youth Mental Health First Aid

Mental Health First Aid (MHFA) is an eight hour certification course available to the general public. Mental Health First Aid is the help offered to a person developing a mental health problem or experiencing a mental health crisis. The first aid is given until appropriate treatment and support are received or until the crisis resolves. The main goals are:

- Preserve life when a person may be a danger to self or others
- Provide help to prevent the problem from becoming more serious
- Promote and enhance recovery
- Provide comfort and support

The state, through the Iowa Department of Education and local education agencies, also received several federal Project AWARE grants which have added significant capacity for Youth MHFA instruction across the state.

Since 2008, 38,079 Iowans have been trained in MHFA. In Iowa, there are 251 certified Mental Health and Youth Mental Health First Aid instructors The instructors are located across the state in a variety of settings which include state staff from the Department of Human Services, Division of Mental Health and Disability Services and the Iowa Department of Education (DE), local law enforcement, regional MHDS staff, and providers of substance use disorder and mental health services. Many local education agency staff have also become Youth MHFA instructors due to the federal Project AWARE grants. The DE will also provide YMHFA to school staff and community members through the STOP School Violence Prevention and Mental Health Training program.

NAMI:

NAMI Iowa is a provider of multiple training and education programs for individuals and families of individuals with a mental illness. Recently, NAMI Iowa has been engaged with a medical school to provide mental health training to medical students. NAMI Iowa also presents an annual conference that provides training and education on mental health-related topics. A list of available trainings is posted on the NAMI Iowa website.
https://namiiowa.org/

Suicide Prevention Efforts

The 2019 report (using 2017 Center for Disease Control data) from the American Foundation for Suicide Prevention reported that 479 Iowans lost their lives to suicide compared to 451 for the year before. Suicide was the second leading cause of death for Iowans ages 15 to 34, and the fourth leading cause of death for ages 35 to 54. Iowa's suicide death rate per 100,000 of the population was 15.13 compared to 14.00 nationally. https://afsp.org/about-suicide/state-fact-sheets/#Iowa. According to the CDC, the suicide rate in Iowa increased by 36% from 1999 to 2016.

The Iowa Department of Public Health (IDPH) is the lead agency for suicide prevention efforts in Iowa. IDPH is a current recipient of a five-year Zero Suicide grant. The grant will fund SUD provider training for the Zero Suicide model and other suicide assessment tools.

Iowa's Department of Education received two grants in October 2014 that also support suicide prevention efforts. The grants are Now is the Time (NITT)-Project AWARE, from SAMHSA, and the School Climate Transformation (SCT) grant, from the U.S. Department of Education. Iowa's grants are aligned with state suicide prevention efforts.

Iowa Suicide Prevention Planning Group and Plan

The Iowa Suicide Prevention Planning Group was convened in August 2014 and is comprised of about 25 members representing diverse suicide prevention organizations and experiences. The SMHA is represented on the planning group by the MHBG State Planner. The Planning Group has met regularly since then, and drafted the Iowa Suicide Prevention Plan 2015-2018. The plan incorporated a goal of reducing the annual number of deaths by suicide in Iowa by 10% by the year 2018, ultimately working toward zero deaths by suicide. The plan identifies objectives and strategies to promote the concept of Zero Suicide in Iowa's health systems. The state is in the process of updating the State Suicide Plan.

Trauma-Informed Care Training

Multiple private providers as well as MHDS regions have promoted trauma-informed care trainings to improve understanding and knowledge of trauma-informed care. MHDS regions are required to develop services that are trauma-informed. Connections Matter training is a curriculum available to educate the public on the effects of trauma on children's development. These trainings are available through a variety of providers across the state.

Your Life Iowa

Your Life Iowa(YLI), a project of the Iowa Department of Public Health, is the integrated hub/system for free and confidential help and information for alcohol, drugs, gambling and

suicide. YLI offers 24/7/365 resources including a telephone helpline, mobile-friendly internet-based communications (e.g., online chat), texting and social media (@yourlifeiowa). Your Life Iowa services are provided by Foundation 2, an Iowa based nonprofit human service agency offering suicide prevention and crisis intervention programs to people of all ages. Foundation 2 has provided crisis counseling by phone since 1970. Effective July 1, 2019, YLI is also available to respond to mental health crises with IDPH and DHS continuing to work together to transition regional MHDS crisis lines into one statewide 24 hour line through YLI.

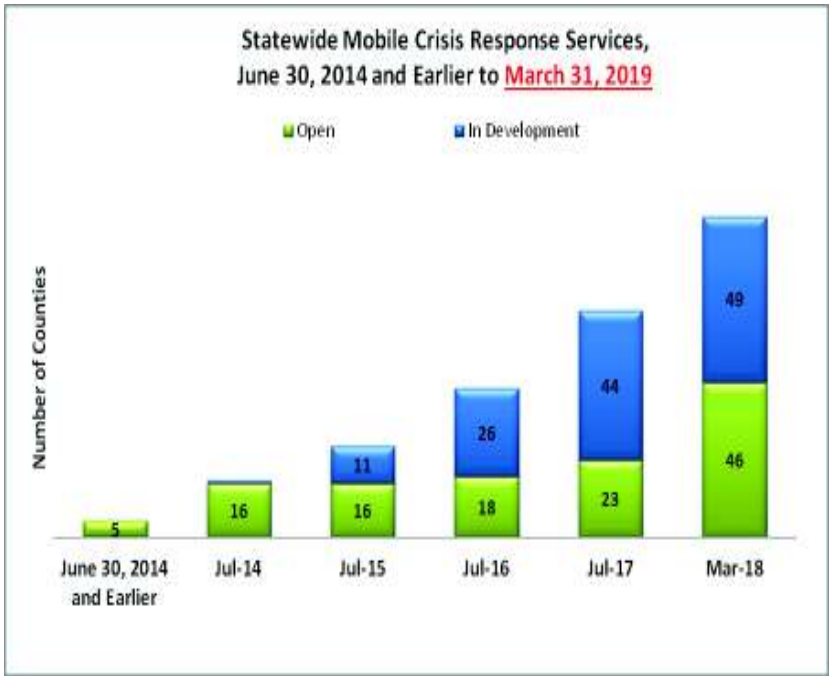
B. EARLY IDENTIFICATION/INTERVENTION

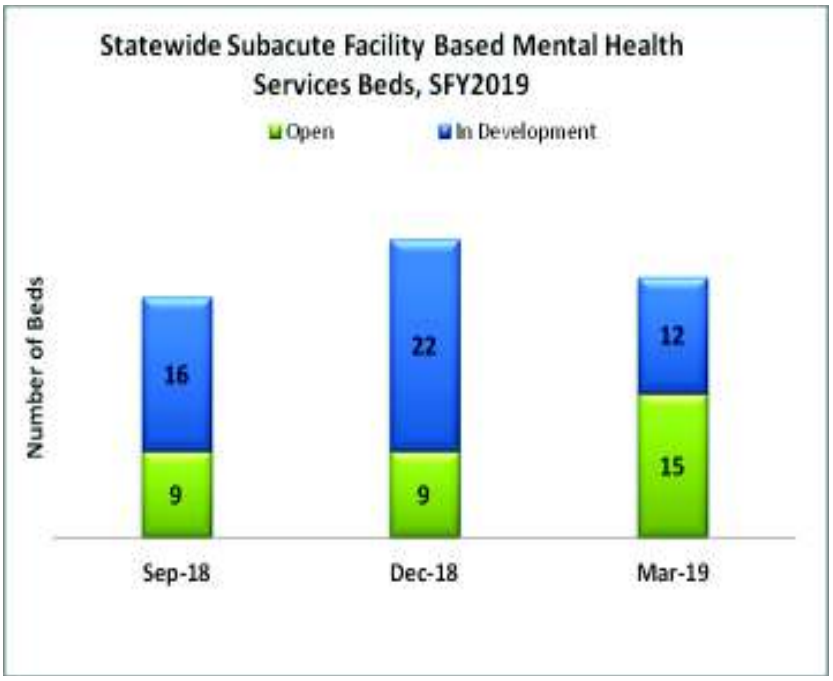
Crisis Services

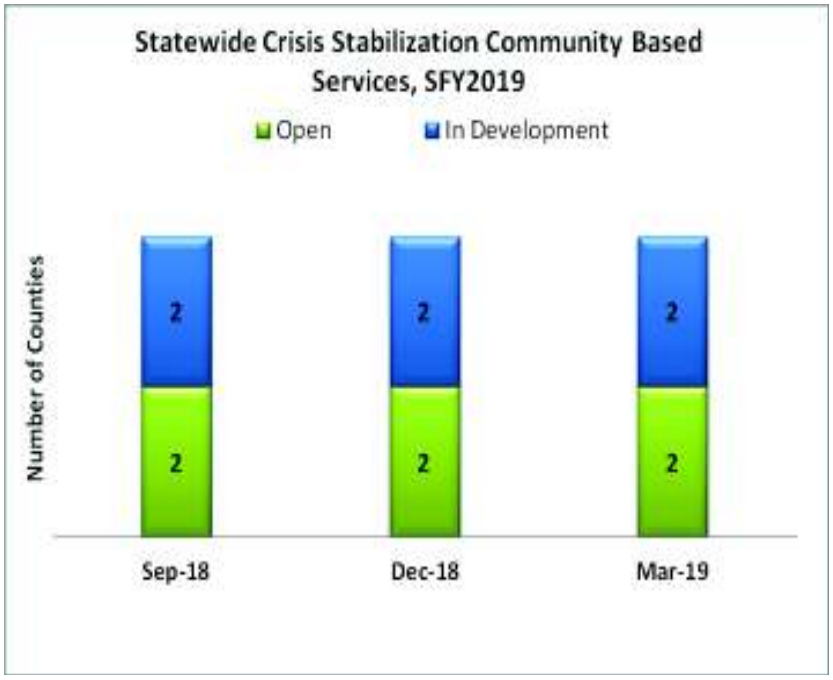
Crisis Services, including 24 hour crisis response, mobile crisis response, crisis assessment and evaluation, 23 hour crisis observation and holding, and crisis stabilization are required services in the MCO contracts. The MHDS regions are required to make the following array of crisis services available to adults effective July 1, 2021. A similar set of crisis services has been mandated for children as well but an implementation date has not been established yet.

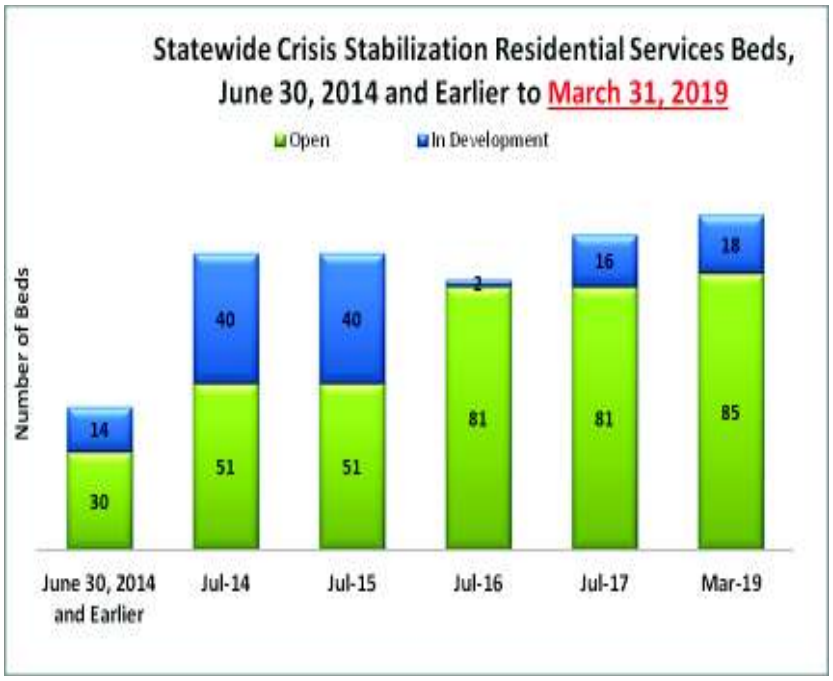
- Access Centers
- Crisis Evaluation
- Crisis stabilization-community and residential
- Mobile Response
- 24- hour access to crisis response
- 23-hour crisis observation and holding
- Subacute mental health facility treatment

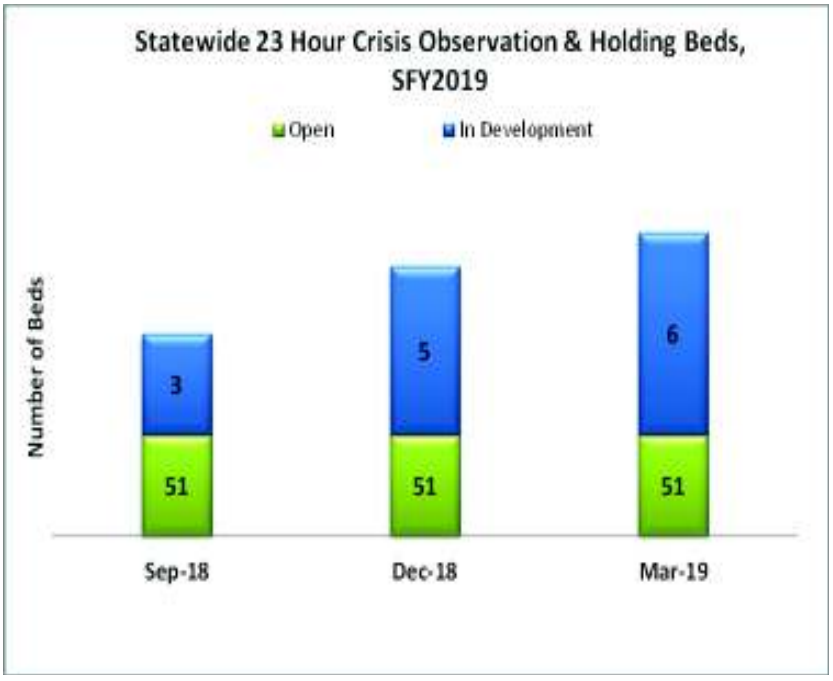
The charts below demonstrate the continued growth in availability of crisis services across the state.




Statewide Subacute Facility Based Mental Health Services Beds, SFY2019
Open
In Development
Number of Beds
16
9
22
9
12
15
Sep-18
Dec-18
Mar-19


Statewide Crisis Stabilization Community Based Services, SFY2019
Open
In Development
Number of Counties
2
2
2
2
2
2
Sep-18
Dec-18
Mar-19





*Source: MHDS Regions Statewide Dashboard SFY19 Quarter 3

Crisis Intervention Team (CIT)

The Iowa Law Enforcement Academy (ILEA) at Camp Dodge, in Johnston, Iowa, is a training facility for new recruits and experienced law enforcement officers from all over the state of Iowa. ILEA has included Crisis Intervention Team (CIT) training (up to 40 hours) in the multi-week training for all new recruits.

Multiple city and county law enforcement organizations have begun training their officers as well. The chart below shows the growth in counties with CIT-trained officers in the last 2 years.

*Source: MHDS Regions Statewide Dashboard SFY19 Quarter 3

Early ACCESS

Early ACCESS is Iowa's system for providing early intervention services. It is available to infants and toddlers from birth to age three years who:

- have a health or physical condition that may affect his or her growth and development
  OR
- have developmental delays in his or her ability to play, think, talk, or move.

The first three years of a child's life are the most important when setting the foundation for ongoing development. Starting supports and services early improves a child's ability to develop and learn. The focus of Early ACCESS is to support parents to help their children learn and grow throughout their everyday activities and routines. This means Early ACCESS service providers work with parents and other caregivers to help their children develop to their fullest potential.

Iowa's area education agencies (AEAs) are responsible for administration of Early ACCESS across the state to ensure that no matter where a family lives in Iowa, services will be available. Currently, Iowa is divided into nine AEA regions.
Service coordination, assessments, evaluations and any needed early intervention services provided by Early ACCESS are available at no cost to families.
Four state agencies are responsible for the state-level early intervention system:

- Iowa Department of Education (lead agency),
- Iowa Department of Public Health,

- Iowa Department of Human Services, and
- University of Iowa's Child Health Specialty Clinics

1st Five Healthy Mental Development

Iowa's 1st Five Initiative builds partnerships between physician practices and public service providers to enhance high quality well-child care. 1st Five operates in 88 of Iowa's 99 counties, serving local pediatric and family practice providers. 1st Five promotes the use of standardized developmental tools that support healthy mental development for young children in the first five years. The tools include questions on social/emotional development and family risk factors, such as depression and stress. When a medical provider discovers a concern, the provider makes a referral to a 1st Five coordinator. Shortly after receiving the referral, the coordinator then contacts the family to discuss available resources that will meet the family's needs. Often these intervention services are related to the behavioral health and developmental needs of the child and/or family. 1st Five supports a community-based systems approach to building a bridge between primary care and mental health professionals.

Iowa Association for Infant and Early Childhood Mental Health-Early Childhood Mental Health Consultation

A focus of this organization is to develop professional competency standards for providers of early childhood services and supports. The organization offers endorsement pathways in infant mental health for individuals working with young children using the Michigan Infant Mental Health Competencies. The organization also offers webinars to the public on topics such as young children and autism, and provides resources to providers and the public on infant and early childhood mental health. Organization leaders advocate for inclusion of promotion and prevention activities focused on young children and their families as part of the statewide mental health and disability services system. Members are also part of IDPH's efforts to increase early childhood mental health consultation in Iowa. IDPH along with a private/public multi-agency stakeholder group has just completed a multi-year SAMHSA-funded consultation program with national experts for the purpose of developing an early childhood mental health consultation system in Iowa. IDPH was recently awarded a SAMHSA Project LAUNCH grant which includes a goal of building statewide professional infrastructure to coordinate and strengthen early childhood mental health consultation in Iowa.

C. TREATMENT SERVICES

Iowa Medicaid is a major source of funding for mental health services in Iowa. Most services are managed through IA HealthLink which includes two contracted MCOs, Amerigroup and Iowa Total Care. The contractors are required to provide high quality healthcare services in the least restrictive manner appropriate to a member's health and functional status. Contractors are responsible for delivering coordinated services including, physical health, behavioral health, and long-term services and supports. The program is intended to integrate care and improve quality outcomes and efficiencies across the healthcare delivery system.

Services are provided by appropriately credentialed mental health service providers to assure availability of the following services to address the mental health and substance use needs of both adults and children. MCOs are also required to meet access standards for availability of services.

Medicaid Mental Health and Substance Use Disorder Services

- Outpatient therapy provided by a licensed qualified provider including family therapy and in-home family therapy as medically necessary to address the needs of the child or other members in the family;
- Medication management provided by a professional licensed to prescribe medication;
- In-patient hospital psychiatric services including, except as limited, services in the state mental health institutes;
- Services that meet the concurrent substance use disorder and mental health needs of individuals with co-occurring condition;
- Community-based and facility based sub-acute services;
- Crisis Services including, but not limited to:
    - a 24 hour crisis response;
    - b. Mobile crisis services;
    - c. Crisis assessment and evaluation;
    - d. Non-hospital facility based crisis services;
    - e. Twenty-three (23) hour observation in a twenty-four (24) hour treatment facility;

- Care consultation by a psychiatric physician to a non-psychiatric physician;
- Integrated health home mental health services and supports;
- Intensive psychiatric rehabilitation services;
- Peer support services for persons with serious mental illness;
- Community support services including, but not limited to:
    - a. Monitoring of mental health symptoms and functioning/reality orientation,
    - b. Transporting to and from behavioral health services and placements,
    - c. Establishing and building supportive relationship,
    - d. Communicating with other providers,
    - e. Ensuring member attends appointments and obtains medications, crisis intervention and developing a crisis plan, and / Developing and coordinating natural support systems for mental health support;
- Habilitation program services;
- Children's mental health waiver services;
- Stabilization services;
- In-home behavioral management services;
- Behavioral interventions with child and with family including behavioral health intervention services (BHIS) and both Medicaid and non-Medicaid funded applied behavior analysis (ABA) services for children with autism;
- Psychiatric Medical Institutions for Children (PMIC).

Medicaid Substance Use Disorder Services

- Outpatient treatment
- Ambulatory detoxification
- Intensive outpatient
- Partial hospitalization (day treatment)
- Clinically managed low intensity residential treatment

- Clinically managed residential detoxification
- Clinically managed medium intensity residential treatment
- Clinically managed high intensity residential treatment
- Medically monitored intensive inpatient treatment
- Medically monitored inpatient detoxification
- Medically managed intensive inpatient services
- Detoxification services including such services by a provider licensed under Iowa Code chapter 135B
- Peer support and counseling
- PMIC substance use disorder services consisting of treatment provided by a substance use disorder licensed PMIC and consistent with the nature of care provided by a PMIC as described in Iowa Code chapter 135H;Emergency services for SUD conditions
- Emergency services for substance use disorder conditions
- Ambulance services for SUD conditions
- Intake, assessment and diagnosis services, including appropriate physical examinations, urine screening and all necessary medical testing to determine a substance use disorder diagnosis, identification of medical or health problems, and screening for contagious diseases;
- Evaluation, treatment planning, and service coordination
- SUD counseling services when provided by approved opioid treatment programs licensed under Iowa Code Chapter 125
- SUD disorder, screening, evaluation, and treatment for members convicted of Operating While Intoxicated and members whose driving licenses are revoked, if medically necessary
- Court-ordered evaluation for SUD
- Court-ordered testing for alcohol and drugs
- Court-ordered treatment which meets criteria for treatment services
- Second opinion as medically necessary and appropriate for the member's condition and identified needs from a qualified health care professional within the network or arranged for outside the network at no cost to the member.

Iowa Health and Wellness Plan members have a limited set of behavioral health benefits but are able to access the full Medicaid benefit package through determination of medical exemption.

IDPH-funded individuals also have a limited set of the listed Medicaid services available.

Iowa Department of Public Health Substance Use Treatment-Integrated Provider Network (IPN)

The IPN is a competitively procured statewide network of prevention and treatment providers, that offer substance use and problem gambling education, prevention, early intervention, treatment, and recovery support services statewide to individuals at or below 200% of the Federal Poverty Level guidelines. Integrated Provider Network services are funded by the State General Fund appropriation to IDPH for substance abuse and problem gambling services under the Addictive Disorders appropriation, and through the SAMHSA Substance Abuse Prevention and Treatment Block Grant (SABG). Integrated Provider Network contractors

were selected in 2018 through a competitive Request for Proposals process and began providing services January 1, 2019.

Co-occurring Services
There is one PMIC licensed to provide substance abuse treatment and mental health services to individuals up to age 21. Other providers of mental health services are also increasing their co-occurring capability. Of the 23 accredited Iowa CMHCs, 14 are also licensed substance use disorder services providers.

Two of the CMHC providers who are also licensed outpatient substance-use disorder providers are recipients of CCBHC agency grants. These providers are working to integrate mental health and substance-use disorder services using the CCBHC model to provide integrated, community-based services for individuals with mental health or SUD needs.

INPATIENT PSYCHIATRIC CARE AND RESIDENTIAL CARE

Inpatient Bed Tracking

Iowa implemented an Inpatient Psychiatric Bed Tracking system effective August 1, 2015. This system was implemented due to concern expressed by stakeholders and advocates regarding difficulty in locating inpatient psychiatric beds, leading to persons having to travel long distances to receive inpatient care. The bed tracking system allows access to an online, searchable database of available psychiatric beds by authorized users, which includes hospitals, law enforcement, regional administrators, and judicial representatives. Legislation enacted in 2017 requires hospitals with inpatient psychiatric units to report into the bed tracking system twice daily, in order to improve reliability of the data base. Subacute mental health facilities were also added as a facility required to report to the bed tracking system.

Inpatient bed availability for individuals with complex needs, including aggressive behavior or intellectual disabilities in conjunction with mental illness remains difficult to obtain. Local hospitals continue to have issues with patients staying in emergency rooms while waiting for an inpatient bed.

Mental Health Institutes (MHI)

The Iowa Department of Human Services oversees two MHIs, located in Cherokee and Independence. The MHIs provide critical access to quality acute psychiatric care for Iowa's adults and children needing mental health treatment.

The MHIs are licensed as hospitals and provide inpatient mental health services via a total of:

- 64 beds of inpatient psychiatric services to adults
- 28 beds of inpatient psychiatric services to children and adolescents

Specialized Psychiatric Units in General Hospitals

There are twenty six hospitals in Iowa which have licensed inpatient psychiatric units serving children and adults with a total licensed capacity of 802 beds. Total staffed bed capacity is 750, with 529 adult beds, 78 geriatric beds, and 143 child beds. While inpatient psychiatric care is concentrated in metropolitan areas, facilities providing inpatient care are generally available within a two-hour drive of their residence. Mental health and disability service regions are required to ensure that inpatient psychiatric care is available within the region or within

reasonably close proximity (defined in administrative rule as 100 miles or a drive of two hours or less from the county or region).

Residential Care Facilities for Persons with a Mental Illness

The Iowa Department of Inspections and Appeals (DIA) licenses Residential Care Facilities for Persons with a Mental Illness (RCF/PMI). Eight programs, with 10 locations and 120 beds are currently licensed. These programs provide care in residential facilities to persons with severe mental illness who require specialized psychiatric care. While they are scattered around the state, these programs are not readily available in every locale. Iowa is moving toward less dependency on institutional care, leading to some RCF-PMI providers reviewing their business models and seeking ways to provide care in more community-based settings.

Intermediate Care Facilities for Person with Mental Illness:

The Department of Inspections and Appeals also licenses Intermediate Care Facilities for person with mental illness (ICF/PMI). These programs provide care at the intermediate nursing level to persons who also have specialized psychiatric care needs. They may participate in Medicaid as a Nursing Facility for Persons with Mental Illness (NFMI). Medicaid will only fund persons 65 and over in this setting. Currently there are three Iowa facilities that hold this licensure with a capacity of 109. MHDS regions may pay for this level of care for individuals who are not eligible for Medicaid funding.

Psychiatric Medical Institutions for Children (PMIC)

These facilities are a treatment option for children and adolescents with an SED who have behaviors and treatment needs that exceed those that can be met in the home and community. There are 8 private agencies that operate 393 Medicaid-funded beds. 30 of the private facility beds are designated for children ages 12 to 18 with substance use treatment needs.

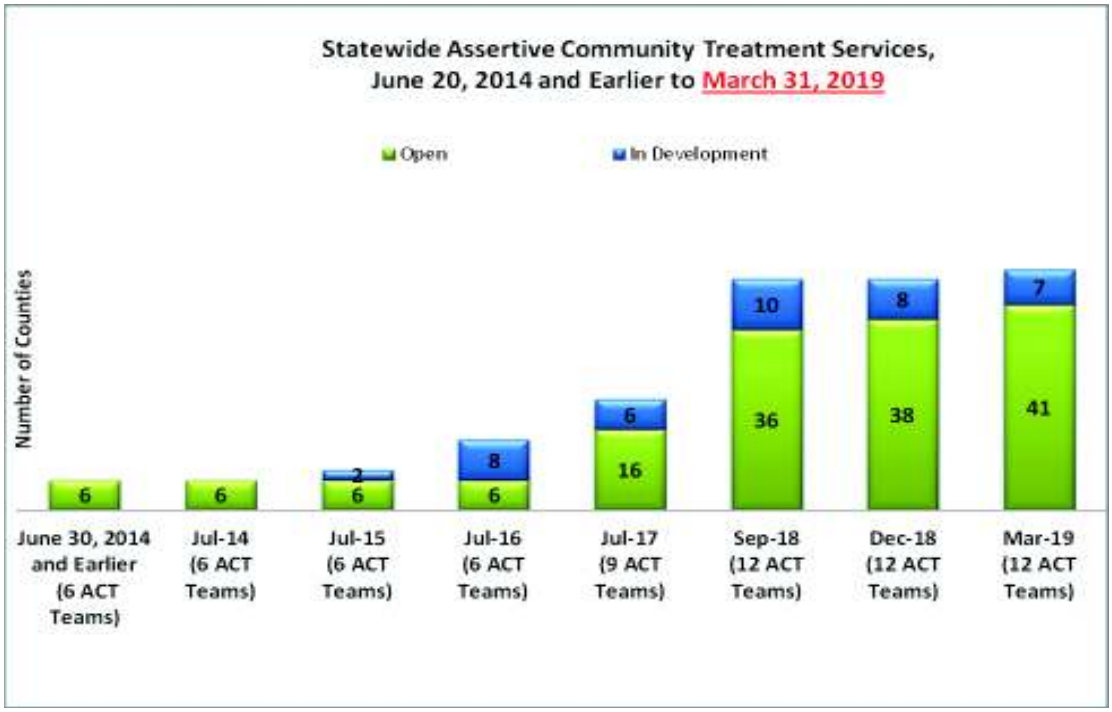
Services provided in PMICs include diagnostic, psychiatric, nursing care, behavioral health, and services to families, including family therapy and other services aimed toward reunification or aftercare. Children served are those with psychiatric disorders that need 24-hour services and supervision. Children may be admitted voluntarily by parental consent or through a court order if the child is under the custody of the Department of Human Services.

Iowa also utilizes out of state PMIC/PRTF facilities for children who are not able to be served within the state of Iowa. As of February 2019, 41 children were in out of state placements. Of the children, nine were placed in PMICs and the rest were placed in foster group care, intermediate care facilities for persons with an intellectual disability or skilled nursing facilities.

COMMUNITY-BASED SERVICES

Assertive Community Treatment (ACT): ACT is an evidence-based practice for individuals with a serious and persistent mental illness who need services outside of standard clinical services. The ACT team of prescribers, mental health professionals, nurses, substance use disorder professionals, and other support providers work with individuals in the community to provide holistic mental health care and supports. The goal is to help individuals with a serious and persistent mental illness be successful in the community and avoid more restrictive treatment settings. In 2018, HF 2456 mandated that ACT be available statewide by July 1, 2021 through a

minimum of 22 ACT teams. Regions were already required to make a set of evidence-based practices, including ACT, available but there was no mandate for a minimum number of teams. Iowa currently has 12 ACT teams serving 41 of Iowa's 99 counties. The following chart demonstrates the growth of ACT services across the state by counties where ACT is available:



***Source-MHDS Regional Dashboards SFY19 Quarter 3**

Case Management Services-Integrated Health Home

As of July 1, 2013, Iowa implemented integrated health homes (IHH) for Medicaid-eligible adults with a serious mental illness and children with a serious emotional disturbance. The health home program was created through Section 2703 of the Patient Protection and Affordable Care Act. IHH services for individuals with an SED or an SMI are required under the contracts with the MCOs and are a Medicaid state plan service.

The goal of the IHH is to provide care coordination and integrated services to populations at high risk of poor health outcomes. Development of health homes is part of Iowa's overall goal to increase availability of supports for individuals with serious mental health conditions that allow them to remain in their homes and communities and have improved health and wellness outcomes. Integrated health homes are available to residents statewide. There are 34 IHH programs across the state. 20 of the 34 IHH are CMHCs. Other IHH are providers of children's residential treatment and community mental health providers. The role of Integrated Health Homes in delivery of services to individuals with an SMI or SED will be further explained in the sections on Children's Mental Health Services, Habilitation, and Case Management.

Through the Integrated Health Home program, Medicaid-eligible individuals who qualify for targeted case management due to a chronic mental illness or a serious emotional disturbance receive care coordination through an Integrated Health Home (IHH) in place of traditional TCM.

The goal is for the individual to receive coordination of services through a team that includes a care coordinator, nurse care manager, and family or peer support specialist. This promotes greater integration of the coordination/case management functions with the actual services and supports provided to the individual.

The MCOs are responsible to ensure that required case management functions occur for individuals with an SED or an SMI. MCOs also are required to provide community based case management (CBCM) to specified populations such as HCBS waiver participants (other than CMH and Habilitation) and long-term care populations such as individuals in nursing facilities and intermediate care facilities for the intellectually disabled.

Habilitation Services

The State Plan HCBS Habilitation program is a Medicaid program operated through a 1915(i) state plan amendment. The Habilitation program provides services similar to HCBS waiver services to individuals with functional limitations typically associated with chronic mental illness. The goal of the HCBS Habilitation program is to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in the community. The goal is to separate rehabilitative and non-rehabilitative services into distinct programs in order to continue the services needed by Iowans, while at the same time assuring that the state remains in compliance with federal regulations. Individuals receiving Habilitation also qualify to receive targeted case management.

As part of the Integrated Health Home program, most individuals receiving Habilitation services receive care coordination through an Integrated Health Home in lieu of case management. This aligns the community supports offered through Habilitation with the mental health and physical health care needs of the individual and provides additional coordination services to those with intensive health needs.

Habilitation services include the following:

- Home-based Habilitation which is individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Home-based habilitation also includes personal care and protective oversight and supervision.

- Day Habilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the participant's private residence. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished 4 or more hours per day on a regularly scheduled basis for 1 or more days per week or as specified in the participant's service plan. Day habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan.

Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to: the ability to communicate effectively with supervisors, coworkers and customers, an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks, workplace problem-solving skills and strategies; general workplace safety and mobility training, the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment. Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community.

- Supported employment services are the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models

Illness Management Recovery (IMR)

A program targeted at reducing hospitalization is Illness Management Recovery (IMR). This program consists of a series of weekly sessions where practitioners help people who have experienced psychiatric symptoms to develop personalized strategies for managing mental illness and achieving personal goals. The program can be provided in an individual or group format, and generally lasts between three to six months. It is designed for people who have experienced the symptoms of schizophrenia, bipolar disorder, and major depression. Some of the components of IMR are:

- Recovery strategies
- Practical facts about schizophrenia, bipolar disorder and major depression
- The stress-vulnerability model and treatment strategies
- Building social support
- Using medication effectively
- Reducing relapses
- Coping with stress
- Coping with problems and symptoms
- Getting your needs met in the mental health system

IMR is an EBP that must be available in each MHDS region or county approved to operate as a region. Regions are coordinating training and technical assistance on this EBP to regional staff and providers to develop capacity and competency in IMR. 10 providers in Iowa are offering IMR services.

Intensive Psychiatric Rehabilitation

Intensive Psychiatric Rehabilitation (IPR) program incorporates recovery-oriented principles as part of a public sector managed care carve-out. IPR is guided by the values of consumer involvement, empowerment, and self-determination. Its mission is to provide enhanced role functioning accomplished through strategies for readiness, skill, and support development.

IPR provides services to adults with a serious and persistent mental illness who are interested in making a community 'role recovery' within the next six months to two years. The concept of role recovery is to engage or re-engage individuals in personally meaningful community roles. The purpose of intensive psychiatric rehabilitation services is to assist the person to choose, obtain and keep valued roles and environments. The four specific environments and roles in which psychiatric rehabilitation will assist the individual are living, working, learning, and social interpersonal relationships. There are 11 IPR providers in Iowa.

Supported Employment/Employment Services

The Department of Human Services (DHS) is involved with several initiatives to increase the number of people with disabilities in competitive integrated employment. DHS' goal is to unify and coordinate these efforts in conjunction with the Olmstead plan, MHDS Regions, Iowa Medicaid, state agency partners and state and local stakeholders so demonstrable improvement can be made in the number of persons with disabilities in competitive integrated employment. This effort includes the evaluating of any new or innovative approaches that can be adopted to help achieve the goal and seeking related program development opportunities.

Iowa Medicaid (Title XIX) provides healthcare and community supports and services for financially eligible children and adults with disabilities as well as a number of other target groups. The goal is for members to live healthy, stable, and self-sufficient lives. Long term community services and supports for people with disabilities, including employment services, are funded through the Medicaid 1915 (c) Home and Community Based Services (HCBS) waivers and the 1915(i) State Plan HCBS Habilitation program. The Partnership for Community Integration Project, Iowa's Money Follows the Person (MFP) initiative also has employment as a priority. MFP is a federal Medicaid demonstration grant to assist persons with intellectual disabilities or brain injuries who are currently residing in Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID) or Nursing Facilities (NF) to transition to the communities of their choice. Employment plays an integral part in community inclusion and the goals of the project.

Iowa Medicaid's Buy-In Program or the Medicaid Program for Employed People with Disabilities (MEPD) is a Medicaid coverage group that allows persons with disabilities to work and continue to have medical assistance. This program has over 15,000 members enrolled.

MHDS is responsible for planning, coordinating, monitoring, improving and partially funding mental health and disability services for the State of Iowa. The division engages in a wide variety of activities that promote a well-coordinated statewide system of high quality disability-related services and supports including employment. Iowa's community-based, person-centered mental health and disability services system provides locally delivered services, regionally managed with evidence-based practices and statewide standards. MHDS Regional leaders, guided by the

regional management plan, coordinate quality community services that support individuals with disabilities not otherwise eligible for Medicaid in obtaining their maximum independence.

MHDS has a seat on the leadership teams of the Iowa Coalition for Integration and Employment (ICIE), along with other state agencies. The ICIE coalition includes service providers, as well as service recipients and family members from all parts of the state. MHDS also co-leads the 2019 Employment First State Leadership Mentoring Project (EFSLMP) with the University of Iowa Center for Disabilities and Development (CDD). The 2019 focus of EFSLMP is building local capacity for implementation of the Individual Placement and Support (IPS) model of supported employment service in four pilot Regions. IPS Supported Employment is an evidence-based practice for individuals with a mental illness.

The pilot projects are in their first year of operation and two have recently received results of their fidelity reviews. These reviews reflected "good" fidelity. Quoting from the independent review summary, "The collaboration and integration of employment within the mental health treatment services and care coordination partners reflects the significant work the partner agency staff members and leaders have put into implementing IPS in communities they jointly serve. The partner agencies are congratulated for their commitment to evidence-based practices and using the IPS fidelity scale to provide direction in all aspects of program development and implementation."

Supported Community Living Programs

Supported Community Living Programs are accredited by the Department of Human Services, Division of MHDS, to provide supervised supported living to persons with disabilities. There are approximately 84 accredited programs which currently provide services to persons with various disabilities.

These programs may be provided in residential institutions but most provide in-home services and supports to persons with a mental illness and other disabilities living in their own homes. Supported Community Living programs operate in every county of Iowa.

D. RECOVERY SUPPORTS

Peer Support Services

Peer Support is an evidence-based practice recognized by the Substance Abuse and Mental Health Services Agency (SAMHSA) and the Centers for Medicaid and Medicare Services (CMS). Peer Support Services are Medicaid billable in Iowa. In Iowa, Peer Support payment is authorized through the managed care organizations or the MHDS Regions.

In February 2015, the Division of Mental Health and Disability Services contracted with the University of Iowa Center for Child Health Improvement and Innovation to provide training for core and continued education, technical assistance, oversight, and recommendation for a certification process for family peer support and adult peer support This contract also works on workforce development for family peer support and peer support services. Peer Support Services are required in the Mental Health and Disability Service Regions. Iowa utilizes certified peer support specialists for employment within the Integrated Health Home, crisis services and peer services. In SFY19 four trainings were held with a total of 76 individuals trained as peer support

and 19 as family peer support specialists. In SFY20 additional trainings are scheduled, including training for supervisors of both family and peer support specialists.

Under IA HealthLink, peer support services for mental health and peer recovery coaching for SUD are both Medicaid reimbursable services. IDPH and DHS have reviewed the curriculum content for the U of I sponsored peer support training and the CCAR curriculum promoted by IDPH. CCBHC planning grant funds were also used to provide additional CCAR training to expand availability of peer recovery coaching. Iowa will accept either version of the training with an additional 6 hours of specialized training either in substance use disorders or mental health.

Respite

Children and adults who access respite services typically do this through one of the HCBS waiver programs, including the Children's Mental Health Waiver for children identified with an SED. Respite providers must be approved to be a Medicaid provider. For children served by Systems of Care, respite is also a key service requested by families. The Systems of Care have provided funding for families of children with an SED in need of this service who are not receiving waiver services.

Wellness Recovery Action Planning

The Wellness Recovery Action Plan (WRAP) model is a person-driven program, which educates clients to manage illness and become active partners in their recovery. WRAP training has been funded by the MHBG in Iowa CMHCs for several years. Wellness centers also offer WRAP to individuals.

E. PROVIDERS OF MENTAL HEALTH SERVICES

Community Mental Health Centers and other Mental Health Service Providers

Community mental health centers and other mental health service providers who act in lieu of a community mental health center are available to provide services across the state for those who are unable to afford services, as well as for those who do not have access to private providers due to income or location. There are 23 CMHC's in Iowa which provide mental health services to adults and children, with the exception of two CMHC's in Polk County, one of which serves only children and one which serves adults. Approximately 74 other agencies are accredited as Mental Health Service Providers and, in limited areas, fulfill the responsibilities of a CMHC. For CMHC's receiving MHBG funding, Iowa law mandates that CMHCs use MHBG funds for the development and implementation of evidence based practices and/or direct services to individuals not otherwise covered by insurance or for services not reimbursed by insurance. The CMHC identifies through its contract with the state how the organization will serve adults with an SMI and children with an SED.

EBP's and best practices supported in FFY19 through MHBG funding to CMHCs include:

- Acceptance and Commitment Therapy
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Mental Health First Aid (MHFA)/Youth Mental Health First Aid (YMHFA)

- Motivational Interviewing
- NAVIGATE model for Early Serious Mental Illness/First Episode Psychosis
- Parent Child Interaction Therapy (PCIT)
- Suicide Prevention
- Trauma-informed care
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- WRAP services

CMHCs serve a defined catchment area, ranging from one county to seven counties. Other Mental Health Service Providers generally serve a specific geographic area. Agencies may be accredited to provide any of the following services: partial hospitalization, day treatment/intensive outpatient, psychiatric rehabilitation, supported community living, outpatient psychotherapy, emergency, evaluation, and crisis services. Accreditations rules are located in Iowa Administrative Code 441-Chapter 24. Community mental health centers, crisis providers, targeted case managers, and certain mental health providers are required to be accredited by the SMHA. Other providers of outpatient mental health services that are housed within larger licensed or accredited health systems such as hospitals, child welfare agencies, or mental health facilities are not included in this count.

Federally Qualified Health Centers

Iowa presently has 57 Federally Qualified Health Centers (FQHC's) sites enrolled as Medicaid providers. FQHC's receive an actual cost reimbursement for Medicaid patients rather than the established rate of reimbursement. To qualify to be an FQHC, the clinic agrees to treat all that present, regardless of insurance or method to pay for services. This has become a valuable resource for adults and families that may not have any insurance coverage and do not qualify for any of the Medicaid programs. FQHC's also provide screening and referral to behavioral health services and in some instances, provide direct behavioral health services. Iowa has one agency that is qualified as both an FQHC and a CMHC, encouraging coordinated care for individuals with co-occurring health and mental health needs. Other mental health providers have collaborative relationships with FQHCs to assist individuals to receive integrated health and behavioral health care.

Mental Health Professionals Statewide

According to the Iowa Health Professions Tracking Center, University of Iowa Carver College of Medicine, for calendar year 2017, there were approximately 232 psychiatrists in the state of Iowa. The majority of psychiatrists practice in metropolitan or urban counties. There were approximately 120 Psychiatric Nurse Practitioners and 33 Physicians Assistants with a Mental Health Specialty.

According to the IDPH Bureau of Professional Licensure, there are: 679 licensed psychologists; 4,246 social workers which includes those at the independent (requires a master's in social work and additional experience), bachelor, and master's levels. There are 357 licensed marital and family therapists and 1,693 licensed mental health counselors, including temporary and fully licensed counselors and therapists. Availability of mental health providers is affected by the aging of the mental health workforce, the numbers of licensed providers who may not be actively practicing, and mental health professionals who work in systems not available to the general

public, such as the Department of Corrections, Veterans Affairs facilities, state MHIs, and educational systems.

The Iowa Department of Public Health /Board of Medical Examiners is responsible for regulating medical and osteopathic doctors. The Iowa Department of Public Health, Bureau of Professional Licensure licenses mental health professionals such as social workers, mental health counselors, and psychologists.

Mental Health Shortage Area Designation

As of April 2019, the Health Resources and Services Administration listed 86 of 99 Iowa counties as having a Health Professional Shortage Area designation for Mental Health. Lack of access to qualified mental health professionals at all levels is an identified gap in the service system.

IDPH manages The Primary Care Recruitment and Retention Endeavor (PRIMECARRE) which was authorized by the Iowa Legislature in 1994 to strengthen the primary health care infrastructure in Iowa. PRIMECARRE allocations currently support the Iowa Loan Repayment Program, with matching federal and state funds. The program offers two-year grants to primary care medical, dental, and mental health practitioners for use in repayment of educational loans. It requires a two-year practice commitment in a public or non-profit site located in a health professional shortage area (HPSA). HPSAs are designed to identify communities with diminishing health care services and provide them with opportunities to improve access to and availability of care. By identifying health professional shortage areas, communities become eligible for state and federal assistance to recruit and retain health professionals, access additional reimbursement dollars, and eventually alleviate the shortage. In 2019, 3 health service psychologists received grants out of the total 16 grants awarded.

Additional psychiatric residency programs have been added in central Iowa to support increased psychiatric capacity in Iowa. In 2019, $400,000 was allocated by the legislature for rural psychiatric residencies and the annual creation and training of four psychiatric residents who will provide mental health services in underserved areas of the state.

IV. SUPPORTS FOR IDENTIFIED POPULATIONS

A. CHILDREN'S MENTAL HEALTH SERVICE SYSTEM

The director of DHS is the co-chair, along with the director of the Department of Education of the new Children's Behavioral System State Board. The Children's Board is tasked with oversight of the development of the legislatively mandated Children's Behavioral Health System. MHDS regions are tasked with providing access to a set of core services for children with an SED in their regions, The state board membership reflects the system of care described above. This representation will be represented at the regional level in the new children's advisory boards. The SMHA also oversees four Systems of Care programs in Iowa which serve 14 of Iowa's 99 counties. The SOCs currently serve children with an SED who are not Medicaid-eligible but require additional supports and services to be successful.

The Iowa system for children's mental health services also includes multiple agencies, within and outside of the Department of Human Services, each with their own eligibility, funding, and

limitations for provision of mental health services. Available services are dependent on type of insurance and locality, as some areas may have a larger service array and more financial investment in children's mental health services.

The Iowa Department of Human Services includes the following divisions which have some responsibility for meeting the mental health needs of children for whom the agency is responsible:

- •The State Mental Health Authority (the Division of Mental Health and Disability Services)
- •The State Child Welfare Authority (the Division of Adult, Children, and Family Services)
- •The Division of Field Operations which oversees local service areas and De-categorization boards, and
- •The State Medicaid authority (Iowa Medicaid Enterprise).

Additional state and local agencies which have funding, service, or regulatory responsibility within the children's mental health system include:

- •The Juvenile Court System,
- •Department of Education which includes Area Education Agencies and public and private Local Education Agencies,
- •Department of Public Health which includes Title V programs, the Child Health Specialty Clinics, substance use disorder prevention and treatment, community health programs, home visiting, and suicide prevention programs
- •Department of Human Rights
- •Department of Inspections and Appeals

Children in need of mental health services have multiple access points by which they may enter the service system. While this is a strength of the system, it can also make it difficult for families to navigate the system. Families are not always aware of the array of services and may choose higher-end, more restrictive types of care because that is what they are aware of, or that is what is most readily available. Private mental health providers of psychiatric and clinical services are available to individuals with Medicaid, as well as those with private insurance, although availability of mental health services is inconsistent across the state, especially in rural areas. Behavioral health intervention services (BHIS) are available primarily to children who are Medicaid eligible.

Iowa has a shortage of child psychiatrists. Most of these are located in urban areas or close to the University of Iowa. Telemedicine is offered through Child Health Specialty Clinics and other mental health providers in order to increase access to specialty mental health services for children with SED and other mental health needs.

There has been no central point of responsibility for children at the local level to provide coordination of children's services; therefore, coordination and case management of children with mental health needs is fragmented. Lack of coordination between multiple providers has been a common complaint from families and stakeholders in the children's system. With the new children's mental health legislation requiring development of a children's system and regional responsibility for access to core services, it is hoped that families will have a place to get appropriate information and support for their children with mental health needs.

Behavioral Health Intervention Services-

Behavioral health intervention services –BHIS are primarily available to children who are Medicaid-eligible. A limited number of programs fund BHIS for non-Medicaid eligible individuals. BHIS are supportive, directive, and teach interventions designed to improve the individual's level of functioning (child and adult) as it relates to a mental health diagnosis, with a primary goal of assisting the individual and his or her family to learn age-appropriate skills to manage their behavior, and regain, or retain self-control.

BHIS enables Medicaid-eligible children and their families, including children receiving the CMH waiver, to access in-home or community-based services in addition to traditional outpatient mental health care without having to enter the child welfare and/or juvenile justice system. BHIS services are also available to children in the custody of the Department of Human Services due to their eligibility for Medicaid.

Specific services available through BHIS include individual, group, and family skill building services, crisis intervention services, and services to children in residential settings. BHIS services are typically provided in the home, school, and community, as well as foster family and group care settings.

Children's Mental Health Waiver

When the Children's Mental Health (CMH) waiver program began in October 1, 2005, it had a capacity of serving 300 children. The current capacity of the CMH waiver is 1,360. The 2019 General Assembly allocated $1.2 million in additional funds to help decrease the waiting list for the waiver. This has led to additional waiver slots being released. The following chart shows the current status of the waiver usage and waiting list as of August 2019.

CMH Waiver Statistics

CMS Slot Cap	1,360	Total slots authorized
Reserved CMH Waiver slots per year	10	For children exiting PMICs, MHIs, or out of state placements
Slots approved	966	
Applications in process	260	
Waiting list	1,372	The next child to be served has an application date of 3/12/18

https://dhs.iowa.gov/sites/default/files/8.1.19_Monthly_Slot_and_Wait_list_Public_0.pdf?08192019191622

Services included in the CMH waiver are respite, family and community supports, in-home family therapy, environmental modifications and adaptive devices, and care coordination through the Integrated Health Homes. In addition, every child receiving services through the CMH waiver has access to full Medicaid services. The goal is to better coordinate the services children

with an SED and their families receive and to ensure that children with an SED are accessing all appropriate services that will enable them to remain in their homes and communities.

Iowa continues to annually make available 10 reserved slots on the CMH waiver for children being discharged from PMIC's, MHI's, or out of state placements These reserved slots are usually used within the first few months of release. This fact, as well as the large waiting list for the CMH waiver demonstrates the need for coordinated, supportive services in order to divert children from more intensive services, and aftercare services for children returning to their communities from PMIC and out of state treatment and placements. Children leaving high-end, restrictive types of treatments and placements need immediate access to services to support a successful transition back to their homes and communities.

Educational System Services and Supports

For children in primary and secondary schools, Area Education Agencies are significant providers of services to children under IDEA. Iowa Area Education Agencies are regional service agencies which provide school improvement services for students, families, teachers, administrators and their communities.

Area Education Agencies (AEAs) work as educational partners with public and accredited, private schools to help students, school staff, parents and communities meet these challenges. AEAs provide special education support services, media and technology services, a variety of instructional services, professional development and leadership to help improve student achievement.

AEAs were established by the 1974 Iowa Legislature to provide equitable, efficient and economical educational opportunities for all Iowa children. AEAs serve as intermediate units that provide educational services to local schools and are widely regarded as one of the foremost regional service systems in the country.

AEA budgets include a combination of direct state aid, local property taxes and federal funds. AEAs have no taxing authority. Funding appears in each local school district's budget and "flows through" the school budgets. Legislation passed in 2019 provided $2.1 million to the AEA's to provide mental health awareness education to educators and schools.

Local Education Agencies also provide early education, intervention, evaluation, special education services, and other services identified in Individual Education Programs and 504 plans for children identified as eligible individuals.

The Iowa Department of Education, in collaboration with area and local education agencies, has implemented the Learning Supports Initiative.

Learning Supports are the wide range of strategies, programs, services, and practices that are implemented to create conditions that enhance student learning. Learning supports:

- promote core learning and healthy development for all students,
- are proactive to prevent problems for students at-risk and serve as early interventions and supplemental support for students that have barriers to learning, and

- address the complex, intensive needs of some students.

Systems of Care

Central Iowa System of Care, Community Circle of Care, Four Oaks System of Care, Tanager Place

The Central Iowa System of Care (CISOC), Community Circle of Care (CCC), Four Oaks System of Care, and Tanager Place serve children and youth ages 0-21 who are diagnosed with a mental health disorder and meet the criteria for Serious Emotional Disturbance. The four programs serve non-Medicaid eligible children and youth and provide access to community-based services and supports. The children and youth served by these programs are assessed to be at risk of involvement with more intensive and restrictive levels of treatment due to their serious behavioral and mental health challenges. All programs provide the following services:

- Care Coordination
- Parent Support Services
- Wraparound Family Team Meeting
- Flexible Funding for BHIS or other in-home services, respite or other mental health services and supports

The purpose of the SOC program is to help the identified child remain successfully in, or return to, their home, school, and community unless safety or clinical reasons require more intensive services. Families referred to an SOC are often at the point of requesting assistance from the court or child welfare system or are seeking PMIC placement. SOC services offer a community-based alternative to children who are at risk of out of home treatment and their families. Services provided include care coordination, access to clinical mental health services, wraparound and family team facilitation, family peer support, and funding for flexible services that strengthen the child's ability to function in the home, school, and community.

Referral sources for SOC programs include parents, schools, DHS Child Welfare, Juvenile Court Services, PMIC's, therapists, and other mental health service providers.

The SOC programs are all Integrated Health Homes for Medicaid-eligible children with an SED. IHH care coordination is reimbursed by Medicaid allowing the SOC funds to be dedicated to providing similar services to non-Medicaid eligible children and families. In SFY19, 487 children were served by the SOC programs.

Services to youth aging out of foster care/transition age youth

Iowa offers supervised apartment living arrangements (SAL) for foster children ages 16 ½ and older with an environment in which they can live in the community with varying levels of supervision. SAL is the least restrictive type of foster care placement in Iowa and the program is designed for older youth for whom neither reunification nor adoption is likely and who are perceived by referring workers and SAL contractors as capable of living within the community with the appropriate level of services, supports, and supervision. Services and supports are tailored to prepare the youth for a level of self-sufficiency necessary to be successful in adulthood. Youth aged 18 or 19 who continue to meet foster care payment and other eligibility requirements may be served in SAL if they have been in foster care immediately before reaching the age of 18 and have continued in foster care since reaching the age of 18. Youth aged 18 or

older must also agree to stay in care by signing a voluntary placement agreement. In SFY18, an average of 69 youth per month received SAL services.

Aftercare is a statewide program which includes pre-exit planning (up to 6 months prior to youth "aging out" of foster care) and case management services for youth ages 18 through 20 who have "aged out" of foster care, court ordered Iowa juvenile detention, or the State Training School. In SFY18, a total of 10,516 children received foster care services. 459 youth aged out of the foster care system and 798 youth received Aftercare services.

Aftercare is voluntary, individualized support to help youth transition successfully to adulthood. Aftercare participants meet at least twice monthly with an Iowa Aftercare Services Network Self-Sufficiency Advocate. Advocates help assess the needs of participants, set goals, develop important life skills, connect youth with community resources, and strengthen personal relationships. Limited funds are available for each participant to help participants in crisis, such as for shelter, food, or other needs associated with achieving identified goals. Regular payments are provided to aftercare participants who attend work or school and meet certain program requirements. These funds are referred to as Preparation for Adult Living, or PAL, and help with rent, transportation, or other needs determined by the youth to move them closer to self-sufficiency.
http://www.iowaaftercare.org/PDF%20files/2018%20IASN%20Outcomes%20Report%20FINAL.pdf

Iowa's regional mental health and disability services systems are also involved in ensuring smooth transitions from child to adult services systems. The regional MHDS system can assist youth with the transition to the adult system. The Integrated Health Home program also assists with transitions for Medicaid-eligible children and youth with an SED or an SMI.

B. SUPPORTS FOR OLDER PERSONS

HCBS Elderly Waiver

Iowa Medicaid has an HCBS Waiver for older persons. Elderly Waiver services are individualized to meet the needs of each member. Individuals must meet the Level of Care for nursing facility care. The Elderly Waiver currently serves 7,766 individuals with 2,260 applications in process. There is no waiting list for this waiver.

The following services are available:

- Adult Day Care
- Assistive Devices
- Case Management
- Chore Services
- Consumer-Directed Attendant Care
- Emergency Response System
- Home Delivered Meals
- Home-Health Aide
- Homemaker Services
- Mental Health Outreach
- Nursing Care

- Nutritional Counseling
- Respite
- Senior Companions
- Transportation
- Consumer Choices Option

Preadmission Screening and Resident Review (PASRR):

Iowa has implemented a strong PASRR process by creating a collaboration within the Department between Iowa Medicaid Enterprise (Medicaid Authority, known as IME) and the Division of Mental Health and Disability Services, (the SMHA). The Department has a contract with Ascend, a Maximus Company to perform all Preadmission Screening (Level I) and Comprehensive Assessment (Level II) PASRR activity. Preadmission screening is federally mandated for all individuals entering a Medicaid-certified nursing facility everywhere in the country and Iowa's program has made enormous strides toward full federal compliance within the past eight years since contracting with Ascend. In SFY19, 35,350 Level 1 PASSRs were completed. Of the total, 11,710 received categorical exemptions and of that amount, 3,000 received full Level II PASSR assessments.

Iowa has instituted a PASRR program that is among the most robust in the country and includes a very proactive training program for all Iowa hospitals and over 450+ nursing facilities, as well as an increasing number of community based services providers. Statewide webinars on topics important to PASRR providers are offered twice monthly, and face to face full-day training events known as the "PASRR Road Show," events, are offered in four locations across the state in the Spring and Fall of every year.

The PASRR process is designed to assure that individuals with mental health, intellectual disability, and related conditions are not placed in nursing facilities unless such a placement is necessary and appropriate. The process identifies the services and supports an individual will need related to their disability and those services and supports they may need in order to return home or to another place at a lower level of care in the community. Iowa's PASRR process includes many innovations including short term approvals which are designed to facilitate faster return to a lower level of care and "links to payment," which permit us to link the PASRR program directly to the income maintenance process of Iowa Medicaid Enterprise.

Since February 1, of 2016, Iowa nursing facilities have been required to enter all of their admission, transfer, and discharge notices into an electronic process known as "PathTracker Plus," which is linked to both PASRR and IME. This electronic process sends an overnight notice to the income maintenance workers who process Medicaid eligibility and payments for facility based care. This innovation has increased efficiencies, eliminated a great deal of paper, and increased the speed and accuracy of payments to Iowa nursing facilities, while also increasing compliance with preadmission screening.

Iowa has implemented a number of other innovations including an in-depth monitoring process of all the care plans developed for individuals identified at PASRR Level II as being in need of "specialized services." The most commonly identified specialized services are behavioral health services such as psychiatric medication monitoring and individual therapy and also include such

things as Peer Support Services, Functional Assessments, and Behaviorally Based Treatment Plans. The review process, known as "ServiceMatters," includes multiple training opportunities, offers in-depth technical assistance, and looks at whether the receiving nursing facility has developed a PASRR compliant care plan. It also explores the extent to which PASRR identified services are being delivered to the individual in a manner that will meet their needs and help them move toward recovery. Iowa was the first state in the country to develop care planning tools to assist our nursing facilities to write care plans that are fully compliant with PASRR.

Some of the latest PASRR innovations include collaboration with the state's licensing and survey agency and Medicaid Managed Care Organizations around how PASRR service delivery and compliance is looked at collectively.

The Iowa Department on Aging (IDA) has a significant collaborative and policy relationship with Iowa's Area Agencies on Aging (AAA), covering all 99 counties. The AAA's have a strong statewide membership organization, the Iowa Association of Area Agencies on Aging (I4a). There are six AAA's in Iowa.

Aging and Disability Resource Centers (ADRC)
Iowa's ADRC system has been branded with the name Lifelong Links, and can be found on the web at: http://www.lifelonglinks.org/ and via phone through a statewide toll free phone number: 1-866-468-7887. LifeLong Link is Iowa's network of Aging and Disability Resource Centers, whose purpose is to expand and enhance the state's information and referral resources for older adults, people with disabilities, veterans and caregivers as they begin to think about and plan for long-term independent living.

A collaborative partnership with Iowa's six Area Agencies on Aging, LifeLong Links is modeled on the "no wrong door" approach, meaning it is available to any Iowan in need of home-based and community services and is accessible through physical locations across Iowa, a toll-free call center (1-866-468-7887) and this website.

With a mission to help Iowans achieve their personal goals for independence and full participation in their community, LifeLong Links provides information about topics and services and connects individuals to local service providers in an effort to support the philosophy of self-directed care.

C. SUPPORTS FOR INDIVIDUALS EXPERIENCING HOMELESSNESS

PATH

DHS- Division of MHDS (the State Mental Health Authority) administers the federal Projects for Assistance in Transition from Homelessness (PATH) program. It is a formula grant program administered by SAMHSA. Iowa will receive a $334,449 for state fiscal year 7/1/2018-6/30/2019.

PATH funds are used for community-based outreach, mental health, substance use services, case management, and limited housing services for people age 18 and over experiencing serious mental illnesses—including those with co-occurring substance use disorders, experiencing homelessness or are at risk of becoming homeless. DHS-MHDS administers contracts with

seven provider agencies located in Cedar Rapids, Council Bluffs, Davenport, Des Moines, Dubuque, Iowa City and Waterloo. In recent years each provider agency exceeded goals for numbers of individuals who were contacted, engaged and enrolled in the program; the percent of individuals enrolled who are literally homeless; and percent of enrollees who receive community mental health services. All of the PATH providers are participating in a centralized intake process to house individuals with the most need first.

The Iowa Council on Homelessness (ICH) staffed by the Iowa Finance Authority is committed to ensuring all Iowans have access to safe, decent and affordable housing. The ICH and its 38 members work to identify issues, raise awareness and secure resources that will allow all homeless Iowans to become self-sufficient. The SMHA has a voting member appointed to serve on the council. The SMHA does not directly fund or manage any programs providing services to individuals in emergency shelter, temporary housing, or permanent supportive housing, but it does work closely with and collaborate with the Iowa Finance Authority, the Iowa Council on Homelessness, the three Iowa continuums of care, and local public housing authorities in providing services to Iowans with a mental illness who are homeless.

DHS-MHDS does not directly fund or manage services targeted specifically to homeless youth, but it does collaborate with the Department of Human Services, Division of Adult, Children, and Family Services, the Iowa Department of Education, and with the organizations listed in the above paragraph to assure that homeless or at-risk youth with behavioral health illnesses have access to all the mainstream services other youth have access to.

S.O.A.R- SSI/SSDI Outreach, Access, and Recovery -
SSI/SSDI Outreach, Access, and Recovery (S.O.A.R.) is a national project to provide intensive assistance in applying for Social Security disability benefits for adults who are (a) homeless or at risk of homelessness and (b) meet Social Security criteria for not being able to work due to the disability. SMHA staff make the recommendation for people to attend the SOAR Leadership Academy paid for by SAMHSA. Currently there are 4 leadership positions across the state to assist the individuals trained to assist people in the application process for disability benefits. These benefits help individuals with serious mental illness and other disabilities obtain access to stable housing and health care.

Housing Supports
Many adults with serious mental illness utilize the "HUD Section 8 Rental Voucher Program". This program increases affordable housing choices for very low-income households by allowing families to choose privately owned rental housing. The public housing authority (PHA) generally pays the landlord the difference between 30 percent of household income and the PHA-determined payment standard, - about 80 to 100 percent of the fair market rent (FMR). The rent must be reasonable. The household may choose a unit with a higher rent than the FMR and pay the landlord the difference or choose a lower cost unit and keep the difference.

Home and Community Based Services Waiver Rent Subsidy Program

The Iowa Finance Authority administers this program. Rental subsidies are available to various disability populations in the state through the home and community-based waiver programs including: Health and Disability; Elderly; AIDS/HIV; Intellectual Disability; Brain Injury and, Physical Disabilities Waivers. Individuals receiving Habilitation and Money Follows the Person are also eligible. The overall purpose of this program is to encourage and assist eligible persons to live successfully in the community until they become eligible for other local, state or federal rent assistance. In Iowa, the program helps an average of 354 Iowans each month to stay in their home and to remain a part of their community. .Iowa like most other states, does not have a waiver specifically targeted to individuals with mental illness; consequently, individuals with mental illness who do not qualify for one of the listed HCBS waivers or Medicaid programs are not able to take advantage of this potentially important opportunity.
http://www.iowafinanceauthority.gov/HCBS

MHDS Regions

MHDS Regions are required to make the evidence-based practice of supported housing available in each region. Regions are working with national experts on permanent supported housing to support programs that provide this service. Most regions provide initial financial support to assist individuals in establishing housing. In SFY18, regions spent $3,995,462 on supported housing programs.

D. VETERANS SERVICES

Iowa has two Veterans Administration (VA) health centers located in Iowa City and Des Moines that provide comprehensive mental health care for veterans. Iowa Veterans are also served by VA systems in Omaha, NE and Sioux Falls, SD. The VA facilities work to connect with community providers to ensure that veterans, service personnel and their families have access to appropriate care and services. The Central Iowa VA system offers inpatient and outpatient MH and SUD treatment. Both Iowa VA systems have presented Veterans Mental Health Summits to education community providers on the behavioral health needs of veterans and service members and the services available through the VA. The summit offers community providers an orientation on VA services and how to help veterans and service members access them. The VA also provides information on the CHOICE program to assist veterans with access to community providers if adequate services are not available within the VA system.

Advocates for veterans continue to identify lack of providers and services, both outpatient and residential, as a gap in the system. Veterans at the summit identified peer to peer counseling as being highly effective in helping veterans in recovery.

Veterans are also represented on the Mental Health Planning Council and the Mental Health and Disability Services Commission. The veterans' representatives offer information and insight into the unique mental health needs of veterans.

E. DISASTER BEHAVIORAL HEALTH RESPONSE TEAM /PROJECT RECOVERY IOWA

The State Mental Health Authority is responsible for administering the disaster behavioral health plan for Iowa. The State Mental Health Authority Administrator assigns a position to serve as the liaison between the federal government disaster grant programs and the state of Iowa. In addition to this function, the position provides oversight and management of the Iowa Disaster Behavioral Health Response Team (DBHRT).

In Iowa, DBHRT responds when local resources have been depleted or are insufficient to respond to the mental health needs of Iowans during all phases of disaster including preparedness through long term recovery. The team is also trained to assist with crisis and critical incident efforts. The team is comprised of trained volunteers who can be deployed within the United States through the Emergency Management Assistance Compact.

Disaster Behavioral Health Response Team members are trained in a wide range of response skills including but not limited to: Psychological First Aid, Critical Incident Stress Management, Mental Health First Aid and Basic Disaster Training.

Project Recovery Iowa is a Crisis Counseling and Assistance Training Program grant authorized under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act). The grant is funded by the Federal Emergency Management Agency (FEMA) and requires a Presidential declaration of disaster for Individual Assistance for short-term behavioral health support when disaster response needs are beyond state capacity. The grant is administered through an interagency Federal partnership between FEMA and SAMHSA.

Project Recovery Iowa is currently active in Fremont, Harrison, Mills, Monona and Woodbury counties and began providing services in April, 2019 and will end in February, 2020. The services funded by the grant are: Individual Crisis Counseling, Basic Supportive Contact, Group Crisis Counseling, Public Education, Community Networking and Support, Assessment, Referral and Resource Linkage.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, and the **Uniform Reporting System** (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several **other data sets** that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[16] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[16] **http://www.healthypeople.gov/2020/default.aspx**

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Footnotes:

Step 2-Identify the unmet service needs and critical gaps within the current system.

This step should identify the unmet service needs and critical gaps in its current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority. The step should also address how the state plans to meet the unmet service needs and gaps.

Unmet service needs and gaps within the current system

Children with Serious Emotional Disturbance (SED)-Identified Needs

According to the most recent prevalence estimate provided by SAMSHA in URS Table 1, Number of Children with Serious Emotional Disturbance, ages 9-17, 2017, https://www.nri-inc.org/our-work/projects/uniform-reporting-system-and-mental-health-client-level-data/ it is estimated that the Iowa SED prevalence ranges from 18,615 to 40,053. The data is provided in a range due to SAMHSA providing prevalence estimates for children at different levels of functioning. The following data compares the prevalence rate to data available regarding services to children with an identified SED in Iowa:

	Number of children approved for the CMH waiver as of 8/1/19*	Percentage of the estimated Iowa SED population	SFY19 -Number of children receiving System of Care services for children with an SED*	Percentage of the estimated Iowa SED population
2017 Estimate of children age 9-17 with a serious emotional disturbance - 40,053	973	2.4%	487	1%

*This data include children younger than the age of 9.

The waiting list for the Children's Mental Health Waiver continues to be significant. As of August 1, 2019, 1,372 children were on the waiting list to be considered for a slot. 260 slots are currently in the process to determine eligibility for the CMH waiver. The length of time from application to notification of slot availability is over a year. In 2019, legislation was enacted that added $1.2 million in additional funds to decrease the waiting list for the CMH waiver. As a result, additional slots are being released in an effort to reduce the waiting list. https://dhs.iowa.gov/sites/default/files/8.1.19_Monthly_Slot_and_Wait_list_Public_0.pdf?081920191622

SOC programs for non-Medicaid eligible children remain limited to 14 of 99 counties in Iowa. The combination of factors including limited waiver slots, limited access to community-based services if not Medicaid-eligible, and lack of providers available to treat children with an SED, places children with an SED at risk of higher-intensity, out of home treatment and placement.

The National Survey of Drug Use and Health, 2016-2017 reports that 14.10 % of Iowa adolescents had at least one major depressive episode in the previous year. This is an increase from 11.9% in 2014-2015.

https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeChangeTabs2017/NSDUHsaeShortTermCHG2017.pdf

The 2018 Iowa Youth Survey, a biannual survey completed by approximately 70,500 Iowa 6th, 8th, and 11th graders provided data regarding students' thoughts of suicide. 10.1% of all students surveyed reported that they had a plan to kill themselves within the past 12 months. This measure has increased 2.2% since the 2016 survey.
http://www.iowayouthsurvey.iowa.gov/images/2018_State/IYS%202018%20State%20Report.pdf

Families of children with mental health issues continue to identify lack of trained providers, lack of crisis services for children, a need for therapeutic school settings, lack of services for children with complex needs such as mental illness and autism as barriers to children with an SED being able to live successfully in the community.

Adults with SMI/Older Adults with Serious Mental Illness/Rural/Homeless

The following prevalences were found:

- SAMHSA URS Table 1 2017 identifies a prevalence rate for Iowa of adults with SMI of 5.4% or 130,277
- The National Survey of Drug Use and Health, 2016-2017, reported that 4.69% of Iowans 18 years or older had serious thoughts of suicide in the past year, 4.59% had an SMI, and 19.02% reported having any mental illness in the previous year. https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeChangeTabs2017/NSDUHsaeShortTermCHG2017.pdf

The need for intensive, community-based services for individuals with complex needs, including individuals with a serious mental illness, substance use disorders, and other co-occurring conditions has consistently been an identified priority of Iowa stakeholders. Multiple workgroups, stakeholders, and advocates have identified lack of appropriate services as a gap across the Iowa behavioral health system and a reason that individuals with complex needs have difficulty obtaining inpatient care when needed, and also have difficulty obtaining community-based care appropriate to the complexity of their behavioral health needs.

As part of the 2018 Complex Needs Workgroup process, the availability of Assertive Community Treatment services was measured across the state using the recommended measure that ratio that .06 percent of the population should have access to an ACT team. By this measure, it was determined that Iowa needed 22 ACT teams. It was enacted in legislation that 22 ACT teams be operational by July 1, 2021. Iowa currently has 12 ACT teams.

Early Serious Mental Illness

Starting in 2014, Iowa has worked diligently to develop Early Serious Mental Illness (ESMI)/First Episode Psychosis (FEP) teams using the Set Aside for Early Serious Mental Illness funds designated in Iowa's MHBG allocation. The current set-aside percentage is 10% of the total award. These funds can only be used for ESMI/FEP services and program support. Iowa has implemented the NAVIGATE model for this population, which is an evidence-based practice. State staff provide technical assistance and contract management for the three programs.

In SFY19, the teams served 72 individuals, an increase from 25 served by 2 teams in SFY17. SAMHSA URS Table 1 2017 identifies an Iowa prevalence rate for adults with SMI of 5.4% or 130,277. The number receiving NAVIGATE services is a very small percentage of the estimated Iowans with an SMI, demonstrating a need for programs to assist people diagnosed with a serious mental illness at the beginning of their illness is essential.

Needs and concerns identified by Mental Health Planning Council members include:
Overall mental health system:

- IHH management-concerns about management of the service under IA Healthlink
- Concerns about IA Healthlink administrative issues with providers, including timely payment of providers
- Concerns about use of restraint and seclusion in school settings, correctional facilities, and facilities for juveniles.
- Lack of mental health workforce, especially in rural areas, for community-based services
- Need for more inpatient beds
- Education for the public on how to access and use mental health services. This includes new crisis services and access centers
- Continued development of a continuum of services for both children and adults
- Telemedicine does not work for everyone. It is a solution to workforce shortages but not all individuals are comfortable with it.
- The state suicide rate has risen consistently since the year 2000.
- The MHPC was not specifically represented on the Children's State Boards, would like representation on state boards and commissions related to mental health.
- Inadequate funding-concerns about low Medicaid reimbursement rates, frozen mental health levies since 1996, and lack of mental health parity enforcement.
- Concern about increase in suicide rate in Iowa of 36% since the year 2000
- Concern that MCOs have not provided high quality healthcare appropriate to members healthcare and functional status

Children with an SED and their families:

- Concern over the availability of residential care
- There is a need to develop children's mental health services at all levels across the state
- There is a need to develop children's mental health crisis services
- Workforce shortage-only 31 child psychiatrists in state
- There is enthusiasm for initial funding of children's mental health crisis services however, there are no sources of adequate annual sustainable funding for long-term support for them at this time. Rural crisis for children also a gap.
- There is a concern over integrated health home (IHH) services operating as intended
- There is a need to increase children's mental health support in schools-therapeutic classrooms, schools, training of teachers, in-school mental health services, school counseling staff.
- There is a need for separate rooms in schools that would be designed to help children with mental health needs to calm down.

- Training in the new Teen Mental Health First Aid model
- Financial support for new children's crisis services to be funded by the MHDS regions

Adults with SMI:

- Not all MHDS Regions have mental health crisis services
- There is a need for mental health services to be developed in settings outside the corrections system
- Increased use of boarding in ERs while waiting for treatment
- Need more services for adults with aggressive behaviors or complex needs
- Mental health services for veterans- concerns about lack of capacity at Iowa Veterans Home in Marshalltown and denial of services there to veterans under age 65
- Mental health services in the corrections system and in jails-concerns about people with mental health needs being in isolation in jails
- Funding for homes that serve veterans has been cut.
- There is a need for more residential treatment beds for individuals with substance-use and co-occurring disorders.
- There is a need for more jail diversion programs and more consistency among programs.
- More trauma-informed care training for professionals in the justice system and emergency room medical staff.

Older Adults with SMI

- There is a lack of affordable housing venues available for older adults with and without SMI
- Concern over PASRR follow-through
- Concern over whether older adults in nursing facilities are medicated to treat their needs, or to make them easier to manage.

Rural and Homeless Individuals with SMI

- There is a need for transportation services
- Peer support services would be very helpful for this population to avoid isolation
- There's a lack of intensive community-based programs like ACT teams
- Not enough affordable housing
- Not enough mental health practitioners

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Provide access to behavioral health services and supports for children with an SED and their families

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase access to regionally funded services and supports for children with an SED and their families.

Objective:

MHDS regions will provide access to core services, as defined in House File 690, for children with an SED and their families.

Strategies to attain the objective:

1. MHDS regions will develop regional children's advisory committees that include parents or relatives of children who utilize services and other specified stakeholders of the children's behavioral health system.
2. MHDS regions will submit transition plans for including children's behavioral health services in the regional MHDS service system by April 1, 2020.
3. Administrative rules defining the core services required in HF 690 will be effective by Feb. 1, 2020.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of children receiving behavioral health services funded by MHDS regions.

Baseline Measurement: 1,946

First-year target/outcome measurement: Regions are developing new services, data for SFY20 will not be available until SFY21.

Second-year target/outcome measurement: 2,141

Data Source:

MHDS regional data

Description of Data:

MHDS regions submit annual data reports to the SMHA regarding demographics of individuals services and types of services provided.

Data issues/caveats that affect outcome measures::

MHDS regional data is submitted to the state December 1 of the year in which the fiscal year ends. The most recent data available is for SFY18. SFY 20 data will not be available until December 2021. Regions are in the process of developing new children's services, therefore increases in children served may not be seen until Year 2 of the plan.

Indicator #: 2

Indicator: Submission of MHDS regional transition plans for children's behavioral health services

Baseline Measurement: 0

First-year target/outcome measurement: 14

Second-year target/outcome measurement: N/A

Data Source:

MHDS regions will submit transition plans to the SMHA.

Description of Data:

Detailed transition plans from each of the 14 MHDS regions.

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Administrative rules defining the core service domains for the children's behavioral health system shall be finalized by Feb. 1, 2020

Baseline Measurement: none -rules do not exist

First-year target/outcome measurement: Publishing of final administrative rules in the Iowa Adminstrative Bulletin

Second-year target/outcome measurement: N/A

Data Source:

Iowa Administrative Bulletin

Description of Data:

Administrative rules documents

Data issues/caveats that affect outcome measures::

N/A

Priority #: 2

Priority Area: Increase access to community-based services for individuals with complex service needs, including individuals with a serious mental illness.

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase access to Assertive Community Treatment (ACT) for individuals with a serious mental illness.

Objective:

Iowa will have 22 ACT teams by July 1, 2021.

Strategies to attain the objective:

MHDS regions will work with local providers and stakeholders to develop ACT teams statewide.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of operational ACT teams in the state

Baseline Measurement: 12 ACT teams as of 03/31/19

First-year target/outcome measurement: 17

Second-year target/outcome measurement: 22

Data Source:

MHDS regional reports to DHS

Description of Data:

number and location of ACT teams in each MHDS region

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Number of MHDS regions meeting access standard: .06 percent of the region's population has access to ACT services

Baseline Measurement: 6

First-year target/outcome measurement: 9

Second-year target/outcome measurement: 14

Data Source:

MHDS regional data reported to DHS

Description of Data:

MHDS regional data reported to DHS

Data issues/caveats that affect outcome measures::

Priority #: 3

Priority Area: Access to 24-hour crisis services for adults and children with mental health and/or substance use disorder needs

Priority Type: MHS

Population(s): SMI, SED, PWWDC, PP, ESMI, PWID, EIS/HIV, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Iowans will have increased access to an array of crisis services as defined in 2018 Iowa Acts Chapter 1056 (HF 2456), 2019 Iowa Acts Chapter 61 (HF 690) and Iowa Administrative Code 441, Chapter 25.

Objective:

Iowans will receive crisis services in the community and through a 24-hour hotline.

Strategies to attain the objective:

1. The Dept. of Human Services and the Department of Public Health will work together to implement a 24-hour statewide crisis hotline for Iowans with mental health needs, building on an existing hotline for individuals with substance use, problem gambling, or suicide concerns.
2. The MHDS regions will develop an array of crisis services as defined in Iowa code and proposed rule.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The Your Life Iowa hotline will be fully operational to serve Iowans with crisis mental health needs.

Baseline Measurement: 0 contacts

First-year target/outcome measurement: 500 contacts

Second-year target/outcome measurement: 1,000 contacts

Data Source:

IDPH, Your Life Iowa data from hotline provider

Description of Data:

demographics of people using the Your Life Iowa hotline for purposes of mental health information or assistance

Data issues/caveats that affect outcome measures::

N/A

Indicator #:	2
Indicator:	Number of individuals receiving crisis services funded by the MHDS regions
Baseline Measurement:	3,083
First-year target/outcome measurement:	Regions are in the process of developing crisis services, SFY20 data wont be available until FY21
Second-year target/outcome measurement:	3.545

Data Source:

MHDS regional data

Description of Data:

number of individuals who received regionally-funded crisis services during the fiscal year.

Data issues/caveats that affect outcome measures::

MHDS regional data is submitted to the state December 1 of the year in which the fiscal year ends. The most recent data available is for SFY18.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention*		$0	$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		$1,054,218	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$0	$0	$0	$0	$0
7. Other 24 Hour Care		$0	$0	$0	$0	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$8,960,853	$0	$0	$0	$0	$0
9. Administration (Excluding Program and Provider Level)***		$527,109	$0	$0	$0	$0	$0
10. Total	**$0**	**$10,542,180**	**$0**	**$0**	**$0**	**$0**	**$0**

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 07/01/2019 MHBG Planning Period End Date: 06/30/2021

Activity	FFY 2020 Block Grant
1. Information Systems	$0
2. Infrastructure Support	$1,267,000
3. Partnerships, community outreach, and needs assessment	$438,500
4. Planning Council Activities (MHBG required, SABG optional)	$160,000
5. Quality Assurance and Improvement	$0
6. Research and Evaluation	$0
7. Training and Education	$1,070,000
8. Total	**$2,935,500**

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Footnotes:

the first amount is estimated SFY20, second amount is estimated SFY21.
Line 2. psychiatric bed tracking-$25,000 +$25,000 +$50,000
Line 2. 24-hour crisis line development -$402,000+$350,000=$752,000
Line 2. UI contract-$232,500+$232,500 =$465,000
Line 3. Office of Consumer Affairs- $149,000 +$149,500=$298,500
Line 3. Staff support for Children's System Board-$70,000 +$70,000=$140,000
Line 4. MHPC expenses +staff support -$80,000 +$80,000=160,000
Line 7. UI Peer Support Training-$500,000+$500,000=$1,000,000
Line 7. ESMI -NAVIGATE Program Training-$35,000+$35,000 =$70,000

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds.
The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

[22] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102-123 **http://www.who.int/bulletin/volumes/91/2/12-108282.pdf**; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52-77

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[25] Social Determinants of Health, Healthy People 2020, **http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39**; **https://www.cdc.gov/nchhstp/socialdeterminants/index.html**

[26] **http://www.samhsa.gov/health-disparities/strategic-initiatives**

[27] **http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/**

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[29] Health Care Integration, **http://samhsa.gov/health-reform/health-care-integration**; SAMHSA-HRSA Center for Integrated Health Solutions, (**http://www.integration.samhsa.gov/**)

[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, **https://www.integration.samhsa.gov/operations-administration/telebehavioral-health**; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, **http://www.americantelemed.org/home**; National Telehealth Policy Resource Center, **http://telehealthpolicy.us/medicaid**;

[31] Health Homes, **http://www.integration.samhsa.gov/integrated-care-models/health-homes**

[32] New financing models, **https://www.integration.samhsa.gov/financing**

[33] Waivers, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html**; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, **http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf**

[34] What are my preventive care benefits? **https://www.healthcare.gov/what-are-my-preventive-care-benefits/**; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); **http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html**

[35] Medicare-Medicaid Enrollee State Profiles, **http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html**; About the Compact of Free Association, **http://uscompact.org/about/cofa.php**

[36] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, **http://www.cbo.gov/publication/44308**

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[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**; National Behavioral Health Quality Framework, Draft, August 2013, **http://samhsa.gov/data/NBHQF**

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

Since 2013, Iowa has implemented Integrated Health Homes (IHH) for adults with a serious mental illness or children with a serious emotional disturbance. The goal of the IHH program is to integrate and coordinate physical health and mental health services to support improved outcomes for the targeted populations. IHH care coordination teams include a care coordinator, a nurse, and a peer support specialist or a family peer support specialist to provide holistic care coordination. Iowa has 34 IHH providers across the state. IHH services are provided by community mental health centers and other mental health providers. One CMHC is also an FQHC and provides medical and mental health services at the same sites. One CMHC is a Primary and Behavioral Health Care Integration grant participant and has primary and behavioral health co-located.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Options for Individuals with co-occurring mental health and substance use disorders to access integrated behavioral health services continue to increase in Iowa. Of the 23 accredited community mental health centers in Iowa, 13 are also licensed outpatient substance use disorder providers. This is an increase of 3 dually licensed/accredited CMHCs since the submission of the FY2018-19 MHBG plan. Provider associations represent both mental health and substance-use disorder providers. Two of the providers who were part of the state's original CCBHC grant application have since been awarded CCBHC state grants to continue implementing the CCBHC model of providing integrated mental health and substance-use disorder care in the same agency. The Departments of Human Services and Public Health (SMHA and SSA) have continued to work together on legislative workgroups and initiatives, including the complex needs workgroup and the children's state board. HF766 enacted in 2019 directed the Directors of the Departments of Human Services and Public Health to develop recommendations for the enhanced delivery of services for co-occurring conditions. The directors are to submit a report to the Governor and general assembly to address opportunities for reducing the administrative burden on the departments and providers, evaluate the use of an integrated helpline and website and improvements in data collection and sharing of outcomes, and create a structure for ongoing collaboration. The directors shall submit a report including findings, a five-year plan to address co-occurring conditions across provider types and payors, and other recommendations to the governor and general assembly by December 15, 2019.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ○ Yes ○ No

b) and Medicaid? ○ Yes ○ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ○ Yes ○ No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ○ Yes ○ No

b) Health risks such as

ii) heart disease ○ Yes ○ No

iii) hypertension ○ Yes ○ No

iv) high cholesterol ○ Yes ○ No

v) diabetes ○ Yes ○ No

c) Recovery supports ○ Yes ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ○ Yes ○ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ○ Yes ○ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

10. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for **Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	○ Yes ○ No
b) Ethnicity	○ Yes ○ No
c) Gender	○ Yes ○ No
d) Sexual orientation	○ Yes ○ No
e) Gender identity	○ Yes ○ No
f) Age	○ Yes ○ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ○ Yes ○ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ○ Yes ○ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ○ Yes ○ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? ○ Yes ○ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ○ Yes ○ No

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

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[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ○ Yes ○ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☐ Leadership support, including investment of human and financial resources.
- **b)** ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☐ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☐ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☐ Quality measures focus on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ○ Yes ◉ No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? ◉ Yes ○ No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

In 2015, Iowa implemented NAVIGATE, an evidence based model to specifically serve individuals experiencing First Episode Psychosis. The specialized intervention is based on a national model which requires specific training and implementation of the model. Iowa currently has three teams in different sites within the state.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Through the NAVIGATE team-based model, services are coordinated and integrated among the team members. Iowa's NAVIGATE teams also employ a community support worker to coordinate services needed outside of the NAVIGATE team. State staff and NAVIGATE team staff have also presented about the NAVIGATE programs at state-wide mental health conferences.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? ○ Yes ◉ No

5. Does the state collect data specifically related to ESMI? (•) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? (•) Yes ( ) No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Iowa has three NAVIGATE teams located in eastern, central, and western Iowa. Iowa also provides specialized technical assistance to the three NAVIGATE teams.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

Iowa will maintain the three NAVIGATE teams and work with the teams to increase the number of individuals served.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Iowa collects data from each of the NAVIGATE teams on a quarterly basis. The data is collected by each team entering data into spreadsheets. Once received, Iowa aggregates the individual team data to establish data on a statewide basis. The aggregation occurs twice a year.
Iowa has only collected data for the most recent fiscal year. There is insufficient data at this time to determine the impact. It is generally viewed that, without the 10% set aside, no teams would have been established.

10. Please list the diagnostic categories identified for your state's ESMI programs.

The diagnostic categories included for NAVIGATE: Non-affective psychoses – Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, Brief Psychotic Disorder, or Psychotic Disorder NOS.

Please indicate areas of technical assistance needed related to this section.

none at this time

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person?s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person?s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person?s needs and desires.

1. Does your state have policies related to person centered planning? (•) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

N/A

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Integrated health homes which provide care coordination for Medicaid-eligible individuals with an SED or an SMI and recipients of the HCBS Children's Mental Health Waiver and HCBS Habilitation Services are required to use person-centered planning (PCP) processes for all individuals they serve, whether they receive an HCBS service or not. DHS, in conjunction with the MCOs and provider agencies has offered PCP training. For HCBS services, PCP is required and is identified in Iowa Adminstrative Code. IHH care coordinators meet with individuals and their families at the location of their choice to develop treatment plans, identify the individual's strengths, needs, preferences, and goals, and develop plans that reflect those goals. At a system level, the state engages consumers and their families through the Office of Consumer Affairs, peer/family support services to help individuals advocate for themselves and their families,, and collaboration with advocacy organizations such as NAMI.

4. Describe the person-centered planning process in your state.

The person centered process for Medicaid members who receive Habilitation is described in Iowa Administrative Code 441.78.27 (4). The rule describes the requirements for the Medicaid member and/or legal representative's involvement in the development of the plan based on the member's strengths, needs, and preferences in all aspects of service delivery. For accredited mental health service providers, person centered principles are also described in Iowa Administrative Code 441.24 (3).

Please indicate areas of technical assistance needed related to this section.

None at this time

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

no

Please indicate areas of technical assistance needed related to this section

n/a

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state?s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Community-based mental health and substance use disorder (SUD) services:
Outpatient mental health therapy and psychiatry
Outpatient SUD services
Intensive outpatient /partial hospitalization -MH and SUD
Peer support/family peer support services for individuals with a serious mental illness (SMI)/parents of children with a serious emotional disturbance (SED)
Peer recovery coaching for individuals with an SUD
Behavioral Health Intervention Services
Habilitation-1915 I waiver for individuals with functional impairments due to a mental illness
Children's Mental Health Waiver-for children with an SED at risk of hospitalization
Integrated Health Home care coordination for adults with an SMI and children with an SED
Medication Assisted Treatment (MAT) for individuals with an SUD
Crisis Services-mobile crisis response, crisis stabilization-residential, crisis assessment, 23-hour crisis observation and holding
Inpatient mental health and SUD treatment

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	( ) Yes (•) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Descriptions of the services are located in Step 1, Assessment of the Behavioral Health System.

3. Describe your state's case management services

Case management for Medicaid-eligible individuals with a serious mental illness or children with a serious emotional disturbance are provided through Integrated Health Homes (IHH) care coordination teams. Teams consist of a care coordinator, a nurse care coordinator, and a peer support specialist (for adults) or a family peer support specialist (for children with an SED and their families). Teams are to address whole person health and social service needs. For persons eligible for services through the Mental

Health and Disability Services (MHDS) regions, IHH, or regional coordinators of disability services provide case management of regionally funded services.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Iowa passed a law in 2018 that required development of additional services designed to reduce the frequency and duration of inpatient hospitalization. MHDS regions are required to develop an array of crisis services, assertive community treatment teams, intensive residential service homes, and subacute treatment facilities. Each of the 14 MHDS regions is required to have these services available by July 1, 2021. Some of these services are already available while others are currently in development.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	130,277	
2.Children with SED	40,053	

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The state uses the most recent SAMHSA prevalence data (2017). The state does not specifically identify statewide incidence of the target populations. The state plans services based on actual service usage, data collected from Iowa Medicaid and the MHDS regions, input from consumers, stakeholders, and funders on strengths and needs of the mental health system and direction of state and legislative leadership regarding overall system goals.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	○ Yes ◉ No
b)	Educational services, including services provided under IDE	○ Yes ◉ No
c)	Juvenile justice services	○ Yes ◉ No
d)	Substance misuse preventiion and SUD treatment services	○ Yes ◉ No
e)	Health and mental health services	○ Yes ◉ No
f)	Establishes defined geographic area for the provision of services of such system	○ Yes ◉ No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

The SMHA manages the federal PATH program for individuals with a mental illness at risk of experiencing homelessness. Seven agencies provide PATH outreach services in rural and urban communities across the state. Most MHDS regions are a combination of rural and urban counties and are required to meet access standards to core services for all counties in their regions. The MHDS regions are working to increase access to services for individuals with an SMI in rural areas by supporting development of ACT teams in rural areas.

b. Describe your state's targeted services to the homeless population.

The MHDS Regions are working to develop supported housing programs to address needs of individuals with an SMI who are not able to maintain or obtain housing. The SMHA also works with the SOAR project to increase capacity of Iowa providers and agencies to assist individual inapplying for SSI/SSDI. Access to disability assistance helps individuals obtain and maintain housing.

c. Describe your state's targeted services to the older adult population.

The SMHA provides oversight of the PASSR process which screens all individuals seeking admission to nursing facilities for mental health or intellectual disabilities. The SMHA coordinates training on this process with providers and works with the PASSR contractor to review treatment plans to ensure that individuals are receiving all appropriate services while in nursing facilities and are also provided supports needed to return to community settings when indicated. Iowa's PASSR process also emphasizes use of short-term stays in nursing facilities to encourage return to lower levels of care when appropriate.
Iowa also has an HCBS Elderly
Waiver which as of August 2019 had 7,766 enrolled members with no waiting list and 2,260 individuals in process to be approved for the waiver. Services provided on the Waiver include:
Adult Day Care
o Assistive Devices

o Case Management
o Chore Services
o Consumer-Directed Attendant Care
o Emergency Response System

o Home Delivered Meals
o Home-Health Aide
o Homemaker Services
o Mental Health Outreach
o Nursing Care
o Nutritional Counseling
o Respite
o Senior Companions
o Transportation
o Consumer Choices Option

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

The SMHA is Rick Shults, Division Administrator, Division of Mental Health and Disability Services (MHDS), Iowa Department of Human Services (DHS). Also housed within DHS are Iowa Medicaid Enterprise, the Divisions of Adult, Child, and Family Services, Fiscal Management, and Information Technology. MHDS works closely with other divisions of DHS to develop mental health policy and
programs. The SMHA's estimated MHBG allocation for FFY20-21 is $10,542,180. The state projects expenditures of $527.109 on administration, $1,054,218 for the 10% ESMI set aside, and the remaining $8,960,853 on allocations to community mental health centers for services to individuals with an SMI or and SED not covered by Medicaid or insurance, training on EBPs, peer support/family peer support training, MHPC support, and other mental health system development projects.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? ○ Yes ○ No

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.
It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? ○ Yes ○ No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? ○ Yes ○ No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? ○ Yes ○ No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ○ Yes ○ No

5. Does the state have any activities related to this section that you would like to highlight.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**

[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? ○ Yes ○ No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ○ Yes ○ No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? ○ Yes ○ No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? ○ Yes ○ No

5. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☑ Psychiatric Advance Directives
- **c)** ☑ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☑ Peer-Operated Warm Lines
- **f)** ☑ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☐ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☐ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Legislation was passed in 2018 and 2019 that requires that an array of crisis services be available statewide. The implementation date for crisis services to adults is July 1, 2021. The implementation date for crisis services to children will be determined in administrative rules which are in development. More detail about development of crisis services in Iowa is located in Step 1- Overview of the State's Behavioral Health System.

Please indicate areas of technical assistance needed related to this section.

Not at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Block grant funding of recovery support services. (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ( ) Yes (●) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Peer support services are funded through Medicaid for Medicaid members and are also a core service through the MHDS regions. Family peer support specialists for parents of children with an SED are also funded through Medicaid. Peer services may be provided as part of the IHH care coordination team for adults with an SMI or families of children with an SED, or may be provided as a standalone service. Several MHDS regions fund wellness centers and warmlines which are staffed by peers. The MHBG funds training of peer support and family peer support specialists statewide.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

IDPH, the SSA, leads recovery support development for individuals with an SUD. IDPH has funded training of peer recovery coaches. Recovery peer coaching is an optional recovery support service in the contracted Integrated Provider Network for the SABG.

5. Does the state have any activities that it would like to highlight?

no

Please indicate areas of technical assistance needed related to this section.

no

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	○ Yes ○ No
Home and community based services.	○ Yes ○ No
Peer support services.	○ Yes ○ No
Employment services.	○ Yes ○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ○ Yes ○ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? ○ Yes ◉ No

b) The recovery and resilience of children and youth with SUD? ○ Yes ◉ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ◉ Yes ○ No

b) Juvenile justice? ○ Yes ◉ No

c) Education? ○ Yes ◉ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ◉ Yes ○ No

b) Costs? ◉ Yes ○ No

c) Outcomes for children and youth services? ◉ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ◉ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ◉ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ◉ Yes ○ No

b) for youth in foster care? ◉ Yes ○ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The director of DHS is the co-chair, along with the director of the Department of Education of the new Children's Behavioral System State Board. The Children's Board is tasked with oversight of the development of the legislatively mandated Children's Behavioral Health System. MHDS regions are tasked with providing access to a set of core services for children with an SED in their regions, The state board membership reflects the system of care described above. This representation will be represented at the regional level in the new children's advisory boards.

The SMHA also oversees four Systems of Care programs in Iowa which serve 14 of Iowa's 99 counties. The SOCs currently serve children with an SED who are not Medicaid-eligible but require additional supports and services to be successful.

The Iowa system for children's mental health services also includes multiple agencies, within and outside of the Department of Human Services, each with their own eligibility, funding, and limitations for provision of mental health services. Available services are dependent on type of insurance and locality, as some areas may have a larger service array and more financial investment in children's mental health services.

The Iowa Department of Human Services includes the following divisions which have some responsibility for meeting the mental health needs of children for whom the agency is responsible:

- The State Mental Health Authority (the Division of Mental Health and Disability Services)
- The State Child Welfare Authority (the Division of Adult, Children, and Family Services)
- The Division of Field Operations which oversees local service areas and De-categorization boards, and

• The State Medicaid authority (Iowa Medicaid Enterprise).

Additional state and local agencies which have funding, service, or regulatory responsibility within the children's mental health system include:

• The Juvenile Court System,
• Department of Education which includes Area Education Agencies and public and private Local Education Agencies,
• Department of Public Health which includes Title V agencies such as the Child Health Specialty Clinics
• Department of Human Rights
• Department of Inspections and Appeals,

Children in need of mental health services have multiple access points by which they may enter the service system. While this is a strength of the system, it can also make it difficult for families to navigate the system. Families are not always aware of the array of services and may choose higher-end, more restrictive types of care because that is what they are aware of, or that is what is most readily available. Private mental health providers of psychiatric and clinical services are available to individuals with Medicaid, as well as those with private insurance. Behavioral health intervention services –BHIS- are available to children who are Medicaid eligible. BHIS provides skill building services to children with a mental health diagnosis who are in need of additional services beyond traditional clinic-based therapy and/or medication management. BHIS is available to non-Medicaid eligible children in limited areas where SOC or other local funding is available.

Iowa has a shortage of child psychiatrists. Most of these are located in urban areas or close to the University of Iowa. Telemedicine is offered through Child Health Specialty Clinics and other mental health providers in order to increase access to specialty mental health services for children with SED and other mental health needs.

There has been no central point of responsibility for children at the local level to provide coordination of children's services; therefore, coordination and case management of children with mental health needs is fragmented. Lack of coordination between multiple providers has been a common complaint from families and stakeholders in the children's system. With the new children's mental health legislation requiring development of a children's system and regional responsibility for access to core services, it is hoped that families will have a place to get appropriate information and support for their children with mental health needs. Additional detail about services provided in the Children's Mental Health System are identified in Step 1-Strengths and organizational capacity of the system.

7. Does the state have any activities related to this section that you would like to highlight?

no

Please indicate areas of technical assistance needed related to this section.

no

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ○ Yes ◉ No

2. Describe activities intended to reduce incidents of suicide in your state.

IDPH, the SSA, is the lead state agency for suicide prevention efforts. DHS, the SMHA, works collaboratively with IDPH on suicide prevention efforts by participating on the Iowa Suicide Prevention Planning Group, which helps develop and implement the state suicide plan. Updates to the state plan are currently in progress. The planning group is comprised of state agencies, advocates, and providers of prevention and treatment services. The planning group serves as a statewide clearing house for suicide prevention activities and a platform for the members to collaborate when possible.

IDPH operates Your Life Iowa, a phone, text, and chat line for individuals in crisis. Previously, Your LIfe Iowa was not marketed as a mental health crisis hotline but rather to individuals experiencing a suicide, substance- use or gambling-related crisis. Over the last several years, the MHDS regions had developed region-specific crisis lines to assist individuals in a mental health crisis. Some regions also used the regional crisis line as an access point for mobile crisis services. In 2018, HF 2456 was enacted, which directed that IDPH and DHS provide a single statewide 24-hour crisis hotline that incorporated warmline services and that could be provided through expansion of the Your Life Iowa platform. IDPH and DHS have been working to implement this direction, leading to Your Life Iowa being available to individuals experiencing a mental health, SUD, suicide, or gambling-related crisis effective July 1, 2019. While the transition from regional crisis lines to one statewide line is in process, regions will continue to provide crisis line services. In 2019, HF 766 provided funding to IDPH, in collaboration with DHS, to support establishment and maintenance of a single statewide 24-hour crisis hotline for the proposed Iowa children's behavioral health system which could also be provided through Your Life Iowa. This work is in progress as well.

3. Have you incorporated any strategies supportive of Zero Suicide? ◉ Yes ○ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ○ Yes ◉ No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted? ◉ Yes ○ No

If so, please describe the population targeted.

IDPH was awarded a five-year federal Zero Suicide grant in October 2018. The agency is partnering with a suicide helpline provider and substance use disorder treatment programs to ensure statewide reach of the programs provided by the Zero Suicide grant. Education will be provided on the Zero Suicide model and development of Zero Suicide strategic plans.

Please indicate areas of technical assistance needed related to this section.

none

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? ( ) Yes (●) No

If yes, with whom?

DHS, the Department of Education and the Department of Public Health leadership are all involved in the Children's Behavioral Health System State Board which provides oversight of the developing Children's Behavioral Health System. DHS and IDPH are working together to implement a 24 hour crisis line for individuals with mental health and substance use needs, building on the existing Your Life Iowa crisis line.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

MHDS regions work with state staff to address reducing use of unnecessary residential or inpatient services. MHDS regions are in the process of developing crisis services, including short-term crisis residential services and other crisis services for adults and children, jail diversion programs, and housing supports.
MHDS regions will be forming children's advisory boards that will include representatives of the educational system to address the mental health needs of children in each region.
At the state level, DHS-MHDS staff have co trained Youth Mental Health First AId with DE staff
and have consulted with DE on specific situations where individuals request assistance with school-related mental health needs.

Please indicate areas of technical assistance needed related to this section.

none

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The SSA leads planning and implementation of the prevention, SUD treatment, and recovery services. The MHPS includes representation from the SSA to encourage coordination and integration of mental health and SUD service systems. The SSA and SMHA regularly work together on issues of mutual concern

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? ○ Yes ◉ No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ◉ Yes ○ No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The duties and responsibilities of the Council are described in the Council's by-laws which are attached to this document. The Council works collaboratively with the SMHA and has annual joint meetings with the state Mental Health and Disability Commission. MHPC members are also members of other advocacy organizations such as NAMI, work and volunteer to provide peer and family peer support, and advocate at all levels of government for individuals with an SMI or SED.
In response to question #1-SMHA staff held two meetings with a subcommittee of Council members to review the existing MHBG plan and solicit input. Meetings were held on March 19 and May 14, 2019. Additionally, on July 17, 2019, the State Block Grant Planner briefed the entire Council on the structure and requirements of the MHBG Plan and offered additional opportunities for input from the council. Minutes of the last three council meetings and the two subcommittee meetings with the council are attached.

Please indicate areas of technical assistance needed related to this section.

none at this time

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[70]

[70] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Iowa Mental Health Planning and Advisory Council
Bylaws

Effective May 28, 2008 as amended July 23, 2010, March 21, 2012, March 21, 2018, and September 19, 2018

ARTICLE I – NAME

The name of this organization shall be the Iowa Mental Health Planning and Advisory Council.

ARTICLE II – DUTIES AND ACTIVITIES

The purposes of the Iowa Mental Health Planning and Advisory Council (the Council) shall be as set forth in federal law (42 USC 300x-3, Pub. Law 102-321, July 10, 1992, ADAMHA Reorganization Amendments, Public Health Service Act, 106 Stat. 382).

Section 1. Duties

A. To participate in the development of and subsequently review mental health plans for Iowa provided to the Council pursuant to 42 USC 300X-4 (a) and to submit to the State of Iowa any recommendations of the Council for modifications to the plans;

B. To serve as an advocate for adults with serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses or emotional problems;

C. To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within Iowa; and

D. To affiliate, join, and collaborate with groups, organizations, and professional associations that the Council may designate or choose to advance its stated purposes under these bylaws and federal law; and, specifically, to join the National Association of Mental Health Planning and Advisory Councils.

Section 2. Activities

A. To organize as a proactive and effectively working Council;

B. To actively participate in the development of the State's Center for Mental Health Services (CMHS) Community Mental Health Block Grant Application;

C. To provide recommendations on State goals according to the criteria of the CMHS Community Mental Health Block Grant;

D. To advise on the allocation of monies received by the State Mental Health Authority through CMHS Community Mental Health Block Grant funding;

E. To advise the State Mental Health Authority on matters that may affect the stated purposes of this Council;

F. To review the annual submission of the CMHS Community Mental Health Block Grant Application and comment on it to the Director of the Center for Mental Health Services;

G. To review the annual submission of a copy of the CMHS Community Mental Health Block Grant Application and comment on it to the Governor of the State of Iowa; and

H. To perform other duties as required by federal regulations.

Section 3. Records

A. The State Mental Health Authority shall maintain all official records of the Council in perpetuity.

B. Copies of any records deemed necessary for Council activities shall be maintained by the State Mental Health Authority.

ARTICLE III – MEMBERSHIP

Section 1. General

To the extent feasible, the membership of the Council shall represent the diverse population of the State of Iowa.

Section 2. Requirements

The Iowa Mental Health Planning and Advisory Council shall abide by the following federal requirements:

A. The ratio of parents of children with a serious emotional disturbance to other members of the Council shall be sufficient to provide adequate representation of children with SED in the deliberations of the Council; and

B. Not less than 50 percent of the members of the Council shall be individuals who are not State employees or providers of mental health services.

(1) A provider of mental health services is an individual who receives money, from any source, to provide direct or indirect mental health services to consumers.

(2) Advocacy, educational, and training organizations, and their employees, shall not be considered providers of mental health services under these bylaws. (Unless they also receive funding for the provision of direct services)

(3) Volunteers and members of advisory and governing boards (of mental health provider organizations) shall not be considered providers solely because of such status.

Section 3. Membership Categories

Membership shall be the following:

A. Seven (7) members representing the principal State agencies with primary responsibility for the following programs:

- Mental Health
- Education
- Vocational Rehabilitation
- Criminal Justice
- Housing
- Social Services
- Medical Services (Title XIX)

(1) Individuals nominated by the principal State agencies shall be reviewed and elected or accepted by the Council. If the Council has concerns or feedback to provide to a principal State agency, through collaboration with the State Mental Health Authority, these concerns can be shared with that agency prior to election of the individual nominee.

(2) Any individual employed by or contracting with the State Mental Health Authority who directly manages or supervises the CMHS Community Mental Health Block Grant may not become a voting member of the Council.

B. Six (6) members representing public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services statewide.

C. Six (6) members who are adults with serious mental illness and current or past consumers of mental health services.

D. Four (4) members (age 16 and over) who are family members of adults with serious mental illness.

E. Six (6) members who are parents, guardians, or primary caretakers of children with serious emotional disturbance.

F. Four (4) other individuals with an interest in supporting the needs of children with serious emotional disturbance and adults with serious mental illness. (There is an expectation for child advocacy representation provided by a representative knowledgeable about the juvenile justice system.) Iowa Code 225C.4 subsection 1 "t" (2010 General Assembly) provides for one (1) representative by a military veteran who is knowledgeable concerning the behavioral and mental health issues of veterans.

G. Four (4) ex-officio members representing the Iowa General Assembly:

- One representative of Senate Democrats
- One representative of Senate Republicans
- One representative of House Democrats
- One representative of House Republicans

(1) Individuals representing the Iowa General Assembly will be nominated by the Majority and Minority leaders of their respective chambers and shall be accepted and confirmed by the Council. If the Council has concerns or feedback to provide to Majority or Minority leaders, these can be shared with that agency prior to election of the individual nominee.

(2) Ex-officio members shall attend no less than biannually with at least one attendance coinciding with the fall session of the Assembly and at least one attendance coinciding with the spring Session of the Assembly.

(3) If ex-officio is not able to meet this obligation, the member should notify the Majority or Minority Leader to nominate a new member.

(4) The council shall notify Majority or Minority Leader if a ex-officio member is not meeting their obligation to allow for review of member appointment or make adjustments so that member can achieve this obligation.

Section 4. Nominations

A. All new members will be subject to a written application process. Renewing members need to notify the nominating committee in writing of their desire to be re-appointed.

B. To be considered, a designated recipient at the State Mental Health Authority must receive the written application for Council membership by the due date specified in the announcement for applications.

Section 5. Voting Rights

A. Each Council member in attendance shall hold one vote.

B. Members may attend meetings and vote by telephone, if technically possible at the meeting location and pre-arranged with staff.

C. No proxy voting is allowed.

D. Under General Ethical Principles Regarding Conflict of Interest in Iowa Code Chapter 68B (Conflicts of Interest), members of the Council shall recuse (abstain) themselves from voting when they have, or anticipate having, a direct financial stake in the outcome of a Council decision, related to, or independent of, their status as a provider of mental health services. (See Article VI – Conflict of Interest)

E. If in the course of business should votes may arise that could directly impact the policies and operations of the entities for which they are employed or representing. If a member perceived that the matter would conflict with or require they feel further review or input from their governing bodies or executive management, members may recuse (abstain) themselves from a vote to allow time to seek further input from their entities.

Section 6. Vacancies

A. Council membership ends when:

(1) A member resigns or dies; or
(2) A member's term ends, and that member does not reapply for another term.
(3) A member fails to meet the Council's minimum attendance policy as defined in Sec. 6(B); or
(4) A majority of the Council terminates the member for just cause, as defined by that majority subject to the procedures required by Sec. 8; or (5) In the case of a principal State agency member, the member's term ends when a new individual is nominated by the principal State agency and confirmed by the Council.

B. All Council members will be held to an attendance policy, as follows: Members will, at a minimum, attend one-half of the regular meetings of the Council for each year. After three consecutive absences, a member shall be notified that his or her position will be considered vacant. Failure to notify the member does not constitute a waiver of the attendance requirements. A Council member will be contacted and the absence policy reviewed after a second consecutive absence.

C. Attendance may be accomplished in person or by telephone conference call.

D. The termination of an individual principal State agency member does not terminate the designated agency's representation on the Council as provided for in Article III, Section 3(A).

E. Resignations by Council members will be automatically accepted and their positions considered vacant immediately.

Section 7. Terms of Membership

A. The membership term of a Council member shall be three years.

B. Membership terms shall be staggered so that one-third of the total number expires each year.

C. To maintain the staggered term structure, each full membership term will begin with the first meeting after the annual meeting.

D. Members elected to fill an unexpired term will begin their term at the first meeting following their election.

E. All new members will be subject to a written application Process. Renewing members need to notify the nominating committee in writing of their desire to be re-appointed.

F. A members elected to fill an unexpired term who wants to continue as a Council member at the end of their term will notify the Nominating committee in writing of their desire to be re-appointed.

Section 8. Termination for Just Cause

A. A Council member or members who feel just cause exists for another member of the Council to be terminated pursuant to Section 6(A)(5), must present a written statement of the reasons for the proposed termination to the Executive Committee.

B. The Executive Committee shall review any such written statement and determine if the matter has merit to be presented to the full Council.

C. Only the Executive Committee is empowered to present a motion for termination of a member for just cause before the full Council.

D. A motion for termination for just cause must be accompanied by a written statement of the reasons for the proposed termination.

E. The Council member who is the subject of the motion must be given an opportunity to respond to the written statement before the Council, prior to any action being taken.

ARTICLE IV – MEETINGS

Section 1. General

A. Regular and special meetings of the Council shall be called by either:

(1) The Executive Committee; or
(2) Eight (8) or more Council members

B. The Council shall meet no less than four (4) times a year.

C. Council meetings shall be conducted according to the current version of "Roberts Rules of Order," as periodically revised, and comply with the requirements of Iowa Code Chapter 21 (Open Meetings) and Iowa Code Chapter 22 (Open Records).

(1) A parliamentarian may be elected by majority vote of the Council to interpret and enforce procedural rules.

D. Members shall be given at least two weeks advance notice of regular meetings. Special meetings may be called and noticed as necessary. Meeting notices must include place, date, and hour. Meeting agendas shall be posted as required by law.

E. The Council's Annual Meeting shall take place at the next regular meeting following the annual federal review of Iowa's CMHS Block Grant Application [November].

Section 2. Quorum

A. No less than two-thirds of the Council members eligible to vote will constitute a quorum. The number of members eligible to vote if all Council positions are filled is thirty-three (33).

B. If, during the course of a meeting the number of members present is reduced below a quorum, the meeting may continue but no vote may be taken.

Section 3. Votes

A. A Majority of the quorum is needed to accept any matter put to a vote

B. The Council Chair casts a vote only in the event of a tie

C. In the process of voting, if a member recuses themselves from a vote (abstain), it shall neither count for nor against the matter at vote. The vote may then be considered accepted by a majority vote of the remaining quorum of members.

D. Should at any time the passing quorum vote falls below the majority number of the total active council membership number, the Council should consider a delay acceptance of the vote until such time a majority of the active council can be either present or able to affirm the matter of action.

E. If a matter of action does pass with less than a majority number of the total active council, clarification and delineation of such should be made in the minutes of the meeting.

ARTICLE V – OFFICERS AND COMMITTEES

Section 1. Officers

A. The officers of the Council shall be a Chairperson, a Vice-chairperson, and Secretary.

B. The outgoing Chairperson may be retained in an ex-officio capacity at the will of the council.

Section 2. Nomination and Election

A. Council Members interested in becoming an officer shall notify the Nominating Committee of their intention prior to the annual meeting. The nominating Committee shall bring the list of those interested forward to the full Council.

B. Officers shall be elected annually for one-year terms.

C. Election of officers shall normally take place at the Council's Annual Meeting, but may be called at another date at the discretion of the Executive Committee, if necessary.

D. A quorum of Council members shall elect the officers by majority vote.

Section 3. Terms of Office

A. Officers shall be elected for a one-year term. There shall be no limit to the number of terms an individual member may be elected to office.

Section 4. Duties

A. The Chairperson shall:

(1) Notify members of meetings;
(2) Preside at Council meetings.
(3) Does not participate in voting as Chairperson unless called upon in case of tie (Article IV, Section 3 (B))

B. The Chairperson, in cooperation with the Executive Committee, shall:

(1) Establish and publish the agenda for Council meetings;
(2) Establish and publish an annual calendar for Council meetings;
(3) Report to the federal government (CHMS), the Governor of Iowa, and designated persons or organizations;
(4) Serve as liaison between the Council and other groups and organizations, including the State Mental Health Authority;
(5) Communicate with and regularly report to the Council;
(6) Designate ad hoc committee membership and monitor such committee's areas of focus; and
(6) Perform other miscellaneous functions, as determined or designated by the Council.

C. The Vice-Chairperson shall:

(1) Assume the Chairperson's duties for any period of time that the Chairperson is unable to do so;
(2) In the event that the Chairperson is unable to complete his or her term, act as Temporary Chairperson until the Council elects a new Chairperson;
(3) In the absence of the Secretary in a meeting, serve as Secretary,
(4) Serve as a voting member of the Executive Committee and

(5) Guide the mentoring process for new members and/or youth members.

D. The Secretary shall:

(1) Serve as a voting member of the Executive Committee
(2) Monitor the maintenance of minutes and records of the Council's business and ensure that minutes and records are compiled and maintained by the State Mental Health Authority to be preserved in perpetuity;
(3) Assume the Chairperson's duties for any period of time that both the Chairperson and Vice-Chairperson are unable to do so; at the will of the Council, staff shall take the minutes of all Council meetings and shall make minutes available for review and feedback by the Secretary and Executive Committee prior to presentation to the full Council; and
(4) If the staff person cannot be present or designate a replacement, the Chairperson shall appoint a council member to take minutes

Section 5. Standing Committees or Workgroups in General

A. Standing committee members shall be elected annually by a majority vote of the Council at the meeting following the annual meeting.

B. Standing committee/workgroup chairs shall be elected by majority vote of the committee/workgroup members.

C. In electing standing committee members or appointing workgroup members, efforts will be made to reflect the diversity of the Council membership categories.

D. Three (3) standing committees are authorized by these bylaws:

(a) Nominations Committee;
(b) Executive Committee;
(c) Monitoring and Oversight Committee.

Section 6. Nominations Committee

A. The Nominations Committee shall consist of five (5) Council members.

B. The Nominations Committee shall conduct outreach to diverse communities.

C. The Nominations Committee shall nominate persons for the offices of Chairperson, Vice-chairperson, and Secretary for consideration by the entire Council.

D. The Nominations Committee shall be responsible for soliciting and reviewing applications for Council membership, and making recommendations to the Council. A Council vote accepts or does not accept the application for membership.

Section 7. Executive Committee

A. The Executive Committee shall consist of: the Chairperson, the Vice-Chairperson, the Secretary, and the Chairs of the Standing Committees. At the will of the Council, the past Chairperson can be an ex-officio member.

B. The Executive Committee shall review Conflict of Interest Disclosures and make recommendations to the full Council on Conflict of Interest issues.

C. The Executive Committee shall establish ad hoc committees and work groups as needed.

D. The Executive Committee shall:

(1) Establish the agenda for Council meetings;
(2) Establish an annual calendar for Council meetings;
(3) Report, on behalf of the Council, to the federal government (CMHS), the Governor of the State of Iowa, and designated persons or organizations;
(4) Serve as liaison between the Council and other groups and organizations, including the State Mental Health Authority;
(5) Communicate with and regularly report to the Council;
(6) Monitor the maintenance of records of Council business, and deliver any official records to the Mental Health Authority to be maintained in perpetuity.
(7) Perform other miscellaneous functions, as developed or designated by the Council.

Section 8. Monitoring and Oversight Committee

A. The Monitoring and Oversight Committee shall consist of five (5) Council members.

B. The Monitoring and Oversight Committee shall, at their discretion, or on the recommendation of the Council:

(1) Review and comment on work plans submitted by contractors;
(2) Review and comment on budget expenditures made pursuant to the CMHS Block Grant;
(3) Review and comment on procedural issues connected with the CMHS Block Grant;
(4) Monitor and comment on the state of the mental health system in Iowa; and report or make recommendations for action to the full Council.

Section 9. Workgroups

A. The Executive Committee shall create and appoint workgroups committees to carry out any necessary Council business or activities that are not expressly provided for in these bylaws.

ARTICLE VI – CONFLICT OF INTEREST

Section 1. Conflict of Interest Policy

A. The Mental Health Planning and Advisory Council (hereinafter, "the Council") respects the rights of all members in their activities outside of their association with the Council, should such activities not conflict with or adversely reflect upon the Council. It is Council policy to place trust in each member's integrity, judgment, and dedication. It is also important to

avoid even the perception of a conflict of interest. Accordingly, the policy set forth below has been adopted:

(1) All Council members are expected to declare any financial or personal affiliations that could interfere with their effectiveness in representing the interests of individuals with serious mental illness or serious emotional disturbance on the Council, or on their effectiveness in representing the Council to the public.

(2) All Council members shall complete a Conflict of Interest Disclosure Statement, including information on any of the following situations:

(a) Holding a financial interest in a company, organization, or agency that provides services to individuals with serious mental illness or serious emotional disturbance.
(b) Receiving federal CMHS Block Grant funding as a contractor, sub-contractor, employee, provider, or in another capacity.
(c) Membership on other councils, boards, commissions, or public bodies that may have interests conflicting with those of the Council.

(3) In the course of Council business, members will be expected to identify instances when a conflict or the appearance of a conflict of interest exists and voluntarily abstain from voting in those situations.

(4) Each member shall sign and place on file with the Council a Conflict of Interest Disclosure Statement annually. (See Appendix A).

(5) Any Conflict of Interest Issues that come to the attention of the Council shall be reviewed by the Executive Committee.

ARTICLE VII – BYLAWS

Section 1. Revision

A. These bylaws may be altered, amended, or repealed, by a majority vote of the Council members at any regular or special meeting of the Council, following a reading, provided that:

(1) The proposed amendments have been given a first reading at a prior meeting, and
(2) That the amendments were submitted to the membership in writing at least two weeks in advance of the meeting where the vote will take place.

B. A bylaws workgroup shall be created by the Executive Committee when necessary for the consideration and development of amendments proposed by Council members or by the officers.

First reading: May 28, 2008

Second reading: Waived May 28, 2008

Adopted: These By-laws are accepted and adopted by vote of the Iowa Mental Health Planning and Advisory Council on May 28, 2008.

Amended: By majority vote of the Council on July 23, 2010, Art. III, Sect. 3F Membership.
By majority vote of the Council on March 21, 2012, Art. III, Sec. 6B Vacancies; Art. V, Sec. 4B Duties.

Appendix A:

Conflict of Interest Disclosure Statement

I, _____, have read the Mental Health Planning and Advisory Council Conflict of Interest Policy (as outlined in Article VI of the Bylaws) and state by my signature below that I am in compliance with it and will continue to observe this policy carefully throughout my association with the Council. In addition, I am disclosing possible conflicts of interest or the potential for the appearance of conflicts of interest, as follows:

_____
_____
_____
_____
_____

Signed: _____

Date: _____

The information in this Conflict of Interest Disclosure Statement will be reviewed by the Executive Committee of the Mental Health Planning and Advisory Council and maintained as part of the official record of the Council by the State Mental Health Authority. If any actual or potential conflict requires attention, the Executive Committee will attempt to resolve the perceived conflict(s).

Ethical Considerations of Council Membership:

Individual Council members have no authority apart from the full Council and cannot act on their own or take action on behalf of the Council without being authorized to do so by the bylaws or the official act of the Council. All Council members are expected to support the decisions of the Council. Council members are discouraged from taking personal action to discredit the dignity and integrity of the Council, staff, or individual members.

MHDS Meeting with the MHPC Block Grant Committee
March 19, 2019

Attendees:
Laura Larkin, MHDS
Teresa Bomhoff, MHPC Chair
Kim Wilson, MHPC
Julie Maas, MHDS

Meeting Discussion

- Laura said that she would like to review the previous block grant application and discuss updates that have occurred since the last application was submitted
- Laura noted that the language related to managed care organizations will be updated to reflect United Healthcare leaving Iowa and Iowa TotalCare starting in July
- Laura said the complex service needs legislation and children's mental health legislation will be included in the plan as they are major system changes
- Teresa Bomhoff said that she would like it to be reflected that the Children's State Board or legislative workgroups did not include members of the MHPC
- Language related to the children's mental health and well-being advisory committee will need to be updated and the Children's State Board's work included
- Additional activities and programs related to mental health to add to the application:
    - Mental health exhibit and programs at the Science Center
    - Regional EBP training, suicide prevention and MHTTC work
    - AEA brain conference
    - Stepping Up Initiative
    - CIT trainings that are taking place across Iowa
    - NAMI training of med students at Des Moines University
    - Make it Okay – marketing plan from Unity Point
    - Mental Health First Aid
    - Please Pass the Love
    - Zero suicide and increase of suicide rates
    - Parent support groups
    - Therapeutic schools
    - ACES360
    - DBHRT update due to flooding
    - Development of children's crisis services
    - Workgroups for psychiatric intensive care and mental health commitments
    - Psychiatric bed tracking system
    - Mental health workforce initiatives and concerns
    - Mental health education for educators
    - Supported employment initiatives

- Teresa recommends using the MHDS dashboard charts in the plan
- The legislative workgroups will be included (tertiary care and pre-commitment screening)
- Information about supported employment to include how many employment specialists Iowa has and other data related to supported employment

The committee will meet again on May 14, 2019 and will review the next section, Planning Steps.

MHDS Meeting with the MHPC Block Grant Committee
May 14, 2019

Attendees:
Teresa Bomhoff, MHPC Chair
Ken Briggs, MHPC Vice-Chair
Kim Wilson, MHPC
Laura Larkin, MHDS
Julie Maas, MHDS

Meeting Discussion

- Laura reviewed the notes from the previous Block Grant Committee meeting and asked if there was anything that should be updated, changed, or added. No changes were made
- Laura said that the Planning Steps section of the application is about strengths, unmet service needs, and critical gaps in the system
- The section is broken up into children, adult, and overall unmet service needs and gaps
- The Committee discussed adding the following items related to children's services:
    - Teen Mental Health First Aid to the application since a pilot program will be starting in the fall
    - Orchard Place and Amos are working together to implement a children's mobile crisis team in Polk County
    - Using SAMHSA prevalence table information to compare children on the HCBS waiver and children in systems of care programs
    - Funding for the children's mental health waiver
    - Training for school staff
    - Family First legislation
    - Workforce shortage
- The Committee discussed adding the following items related to adult services:
    - Complex needs information
    - Building a continuum of services for both children and adults
    - More inpatient beds throughout the state
    - There will be a learning curve related to access centers and how to use them within the continuum of services
    - Education on how to use services and when to use services is needed
- The Committee discussed adding the following items related to overall system concerns:
    - Telemedicine doesn't work for everyone and it is often used as the answer to all problems
    - Suicide rate has continued to increase since 2000
    - Funding for veteran homes have been cut drastically
    - Need more substance abuse treatment beds and co-occurring beds

    - Need more jail diversion programs and consistency among the current programs
    - More trauma informed trainings taking place among judicial staff and ER doctors
    - Two agencies were awarded federal grants to become CCBHCs
- Next Steps:
    - Council will review the full document and Laura will send out progress updates and sections as completed

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL
July 17, 2019 10:00 am to 3:00 pm
Iowa Lutheran Hospital, Room 2
700 University Avenue, Des Moines, IA
MEETING MINUTES

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL MEMBERS PRESENT:

Teresa Bomhoff
Kenneth Briggs Jr.
Jim Cornick
George Estle
Kathleen Goines
Julie Kalambokidis
Michael Kaufmann
Gary Keller
Anna Killpack
Todd Lange (phone)
Brenda Lechner
LeAnn Moskowitz
Nathan Nash
Carole Police
Donna Richard-Langer
Brad Richardson
Jim Rixner
Jennifer Robbins
Lee Ann Russo (phone)
Dennis Sharp
Rosie Thierer
Heather Thomas
Kimberly Wilson
Brook Whitney

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL MEMBERS ABSENT:
Earl Kelly
Jim Chesnik
Jim Donoghue
Michele Tilotta
Senator Zach Wahl

YOUTH CONSULTANT:
Justen Nash

OTHER ATTENDEES:

Flora Schmidt	Iowa Behavioral Health Association
Adrienne Seusy	Legislative Services Agency
Emily Berry	Iowa Office of Consumer Affairs
Michael Straight	Individual
Kristin Rooff	University of Iowa
Melissa Schwery	Individual

Welcome and Call to Order
Teresa Bomhoff called the meeting to order at 10:01 a.m. and led introductions. Quorum was established with twenty-two members present in person and two members present by phone. Dennis Sharp made a motion to approve the May 15, 2019 meeting minutes. Jim Cornick seconded the motion. The motion to approve the May 15, 2019 minutes passed unanimously.

Committee and Workgroup Reports

Nominations Committee

Ken Briggs said that the committee received applications from Melissa Schwery as a parent of a child with an SED, Heather Wellman as a parent of a child with an SED, and Michael Straight as an individual living in recovery. Jim Rixner made a motion to accept all applicants as Council members. Nathan Nash seconded the motion. The motion passed unanimously.

There was discussion on the attendance policy and vacating people's position due to their attendance. There was discussion on considering why an individual misses a meeting and how many meetings they miss. There was discussion on contacting the individual before vacating their position. There was discussion on when an individual can reapply to be on the Council and who is responsible for contacting individuals after missing two meetings and the Council being kept up to date on attendance.

Ken Briggs made a motion that the two members in question are vacated from their position and Michael Straight seconded the motion. The motion passed unanimously.

Jim Rixner made a motion that individuals who have been vacated from the Council cannot reapply for 1 year after their position has been vacated. Carole Police seconded the motion. The motion passed with the following Council members voting in favor of the motion: Anna Killpack, Brad Richardson, Carole Police, Dennis Sharp, Donna Richard-Langer, Gary Keller, George Estle, Heather Thomas, Jim Rixner, Jim Cornick, Julie Kalambokidis, Kathleen Goines, Ken Briggs, Kim Wilson, LeAnn Moskowitz, Lee Ann Russo, Michael Kaufmann, Nathan Nash, Brook Whitney, and Rosie Thierer. Jennifer Robbins voted against the motion. Brenda Lechner abstained from voting.

Donna Richard-Langer made a motion that the nominations committee will be responsible for reporting attendance at each meeting and contacting members who have missed two meetings. Gary Keller seconded the motion. The motion passed unanimously. A revised policy statement will be sent out to the Council.

There was discussion on the vacancy on the nominations committee. Melissa Schwery volunteered to be on the committee. Donna Richard-Langer made a motion to have Melissa join the nominations committee. Anna Killpack seconded the motion. The motion passed unanimously.

Monitoring and Oversight Committee

Donna Richard-Langer reminded the Council who is on the committee and said the committee is meeting every month. Donna said the last few meetings they have been looking at the contracts DHS has with block grant dollars. Donna updated the Council on the System of Care contracts they reviewed and the purpose of the system of care programs. There was discussion on the federal regulation for how block grant dollars are meant to be spent. Donna reminded the Council of the three purposes for the money: carry out the plan submitted by the state, evaluated the programs carried out under the plan, administration and education relating to providing services under the plan. Donna said the

committee is also working through restrictions on how the money can be spent. The committee would like the Council to review with them how the money should be spent. There was discussion on improving the system as a whole and not program specific. There was discussion on the funding of system of care programs and the use of general funds and block grant funding.

Donna made a recommendation that the Council's recommendations focus on system change and education for policy makers on needed services throughout the state. There was discussion about the importance of people knowing where there are gaps in the system. There was discussion on workforce shortage and strategies for building workforce in the state. There was discussion on wages for frontline staff and peer supports and how rates impact the wages providers are able to offer staff.

Children's Workgroup

Nathan Nash said that he has been involved with the Southeast Iowa Link region with starting children's services in that region. Nathan said that the SEIL region does not have any children's services in the area and asked if the Council would be interested in making it a Council project to bring children's services to that region. There was discussion on the importance of the Council focusing statewide instead of regionally specific program. Teresa Bomhoff suggested a recommendation could be helping regions set up the children's system. There was discussion on the governance structure for the regions in building the children's system. There was discussion on the regional implementation plan and implementation dates. There was discussion on implementation dates and how the administrative rules will help answer some questions.

Teresa updated the Council on the coalition Please Pass the Love has started and encouraged the Council members to look at the different options of participating on the Coalition.

Outreach and Marketing Committee

Rosier Thierer said that she will continue working on the brochure and asked if anyone else would like to join the committee. Teresa Bomhoff said she will join the committee. There was discussion on the purpose of the brochure and the need to establish procedures for distributing communication materials.

The Council broke for lunch at 11:50am and reconvened at 12:45pm.

Public Safety Workgroup

Gary Keller updated the Council on the last public safety workgroup meeting. Gary discussed the concerns about when individuals are released under work release and are not eligible for Medicaid because they are still under a state government facility. There was discussion on how these individuals covered for medication and in the community. Several regions cover medications or appointments for individuals but it isn't a core service. There was discussion on different funding options such as under the justice system. There was discussion on individuals receiving thirty days of medication and barriers of transitioning from prison/jail to the community when released. There was discussion on essential services that aren't core services. There was discussion on medication prescribing and

management as a children's core service but not for adults. There was discussion on the role of insurance in paying for costs. There was discussion on the high percentage of inmates that are incarcerated due to parole violations.

Legislative Workgroup

Teresa presented a handout for the Council to review from a presentation that was given on the state of mental health in Iowa. Teresa said this would be a start on the conversation on legislative priorities but would like input from the Council. The presentation included five topic areas related to mental health in Iowa. Those areas were: prevalence of inpatient hospital beds, workforce, funding, suicide, and criminalization of a medical illness. There was discussion on the need to focus workforce on more than just prescribers but not lose the need for prescribers.

Update from DHS

Laura Larkin said that she was going to give the DHS update and give an update on the mental health block grant plan. Laura said the new Children's Behavioral Health System Board has been appointed and additional members are a member of the MHDS Commission and state departments. DHS will be providing staff support for the Board. There was discussion on how the Mental Health Planning Council does not have a seat on the Board. Laura gave an update on the screening panel which was formed using a grant from Mid Iowa Health Foundation. Laura said an outside facilitator is leading those meetings and they are discussing what is currently going on in Iowa today and where we can build on what is already happening. Laura said that report will go to the Children's Board. Laura said the children's administrative rules in Chapter 25 will be going to the Commission in September to ask them for approval to notice the rule package. Laura said the rules will include service definitions, provider requirements, eligibility requirements, cost sharing requirements, and access standards. There was discussion on how services in the schools are not included in the rule package. There was discussion about how AEAs do not put therapists in schools and the importance of having mental health services in the schools.

Laura gave an update on Your Life Iowa and the statewide crisis line. Laura said the website is being worked on to include mental health information and there was a soft start on July 1. Laura said they are still working out the details with rolling over regional crisis lines and mobile crisis to Your Life Iowa.

Laura gave an update on regional realignment in the northwest corner of the state that included Lyon County moving Sioux Rivers and Woodbury County moving to Rolling Hills. Other regional issues are that Kossuth, Winnebago and Worth counties wanted to leave CSS but DHS assigned them back to the CSS region. They would still like to leave and are discussing that among themselves. At this time the law does not allow for the development of a new region and regions must still meet the requirements.

Laura said Project Recovery Iowa which is the disaster relief program in Western Iowa continues and DHS is applying for all available federal funds. Laura said that community mental health centers are reaching out to individuals to provide assistance and ISU Iowa Concern hotline is still being used as a referral source to the providers. Laura said about 5,000 individuals were reached through Project Recovery Iowa.

Laura said that 1.1 million dollars was appropriated to increase the assertive community treatment rate to $55.83. This change will have to be addressed in administrative rules. Rate changes will go into effect July 1st as soon as programing is completed. Laura said that IME has been working on the release of children mental health waiver wait list. The slots will be released staggered with a total of 386 slots being released with the 1.2 million appropriated. There was discussion about the time lag between when the slot is released and when the child begins receiving services. There was discussion about the number of children on the waiting list already being eligible and how long it can take for children to be enrolled with an integrated health home. There was discussion on the variety of factors that go into how long it takes for a child to receive services after they receive a slot. There was discussion about the application process and eligibility determination process.

Laura gave an update on the mental health block grant plan. Laura said that she has been working with a committee from the Council on updating the plan. Laura reviewed the target populations for the block grant and changes including the children's system and regional changes. Laura said that DHS and IDPH collaborate on writing the plan wherever possible. Laura said that she is gathering input from the Council as she is writing the plan. Laura encouraged the Council to share their priorities and DHS will take them under consideration. Laura said the plan is due September 3rd and will try to get the entire plan out to the Council the last week in August. The Council can then submit formal input which will be included when the plan was submitted.

There was discussion on including mental health and farmers in their priorities. There was discussion on the fiscal note for HF690 and the assumptions including that private insurance will pay for crisis stabilization. Teresa said that the Council can send comments on the Olmstead Plan to Connie Fanselow at MHDS. Teresa reviewed changes to the medical assistance advisory committee and reviewed the advisory councils to DHS.

Laura Larkin said that Rick Shults has delayed his retirement and the interim DHS Director is Gerd Clabaugh who is also the Director of the Department of Public Health.

Public Comment
None

The meeting adjourned at 2:45pm.

Meeting minutes respectfully submitted by Julie Maas

Joint Meeting of the
IOWA MENTAL HEALTH AND DISABILITY SERVICES COMMISSION
and the
IOWA MENTAL HEALTH PLANNING AND ADVISORY COUNCIL
May 15, 2019, 1:00 pm to 4:45 pm
Polk County River Place, Room 2
2309 Euclid Ave, Des Moines, Iowa
MEETING MINUTES

MHDS COMMISSION MEMBERS PRESENT:

Thomas Bouska
Thomas Broeker (phone)
Jody Eaton (phone)
Kathryn Johnson
Shari O'Bannon
John Parmeter
Maria Sorensen
Cory Turner
Richard Whitaker
Russell wood
Lorrie Young
Senator Pam Jochum

MHDS COMMISSION MEMBERS ABSENT:
Dennis Bush
Teresa Daubitz
Geoffrey Lauer
Senator Jeff Edler
Representative Joel Fry
Representative Scott Ourth

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL MEMBERS PRESENT:

Teresa Bomhoff
Kenneth Briggs Jr.
Jim Chesnik (phone)
Jim Cornick
George Estle
Kathleen Goines (phone)
Michael Kaufmann
Gary Keller
Earl Kelly
Anna Killpack
Todd Lange (phone)
Brenda Lechner (phone)
LeAnn Moskowitz
Nathan Nash
Carole Police
Donna Richard-Langer
Brad Richardson (phone)
Jennifer Robbins
Lee Ann Russo
Dennis Sharp
Rosie Thierer
Michele Tilotta
Kimberly Wilson (phone)
Senator Zach Wahls

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL MEMBERS ABSENT:

Harry Olmstead
Heather Thomas
Jim Rixner
Jim Donoghue
Julie Kalambokidis
Kris Graves
Sharon Lambert

OTHER ATTENDEES:

Theresa Armstrong	MHDS, Bureau Chief Community Services & Planning
Kris Bell	Legislative Services Agency
Liz Cox	Polk County Health Services/Prevent Child Abuse Iowa
John Hedgecoth	Amerigroup
Sandi Hurtado-Peters	Department of Management
Brooke Lovelace	Iowa Developmental Disabilities Council
Julie Maas	MHDS, Community Services & Planning
Carrie Malone	Department of Human Services
Flora Schmidt	Iowa Behavioral Health Association
Rick Shults	Division Administrator, Mental Health and Disability Services
Brook Whitney	Iowa Finance Authority
Derrick Willis	University of Iowa/UCEDD

WELCOME AND CALL TO ORDER
MHDS Commission Chair John Parmeter and Mental Health Planning Council Chair Teresa Bomhoff called the meeting to order at 12:31 pm and led introductions.

DHS Welcome – Rick Shults
Rick welcomed everyone to the meeting and said this is an exciting time for a unique gathering of passionate stakeholders with different perspectives and organizations coming together to move things forward. Rick said these two groups deserve a lot of credit for their work, and thanked the members of the Commission and Planning Council on behalf of the Department of Human Services for joining DHS on a journey moving forward.

MHDS Commission Overview – John Parmeter
John said the MHDS Commission was created by state statute, and its membership is prescribed by Iowa Code and members are appointed by the Governor and confirmed by the Senate. The Commission is comprised of representatives from counties, providers, MHDS Regions, Department designees, consumers of services and their family members, advocates, and non-voting legislative members.

John said the Commission is responsible for making certain recommendations to the Department on changes or improvements to the mental health and disability services (MHDS) system. The Commission is also responsible for adopting administrative rules relating to mental health or disability programs.

MHPC Overview – by Teresa Bomhoff
Teresa Bomhoff shared an overview of the Mental Health Planning Council and its activities. She noted several differences between the MHDS Commission and the Council including the Council is authorized by federal law and required as a condition of Iowa receiving federal Community Mental Health Block Grant funds, members are elected according to Council bylaws, and the Council meets bi-monthly (six times a year). Teresa reviewed the Council's three purposes to review Iowa's Mental Health Block Grant Plan and make recommendations to DHS, to advocate for adults with serious mental illness, children with serious emotional disturbance and their families, and other individuals with mental illness, and to monitor, review, and evaluate the allocation and adequacy of mental health services within the state. Teresa also reviewed the federal membership requirements and member categories.

Teresa noted that the Planning Council's bylaws require at least three standing committees. The Executive Committee composed of the Planning Council's officers, the Nominations Committee which recommends applicants for membership to the Planning Council, and the Monitoring and Oversight Committee, which has developed a list of priorities for MHDS.

Iowa Developmental Disabilities (DD) Council Overview – Brooke Lovelace
Brooke thanked the Commission and Planning Council for inviting him to speak. The Developmental Disabilities Council (DD Council) is a federally funded quasi-state agency. Funding for the DD Council passes through DHS, but it functions independently. The DD Council was created as the result of executive action by Governor Ray. The DD Council has a federal mandate to engage in advocacy for systems change, to ensure that individuals with developmental disabilities have services in the community, culturally competent resources, and that they can live independently in communities they choose.

The DD Council has a prescriptive membership, much like the Planning Council and the Commission. 60% of the members must be people with disabilities and their family members, and within that 60%, one third must be individuals with developmental disabilities, one third must be family members, and one third can be either. In addition to that there are mandated agencies that must be represented, including Iowa Vocational Rehabilitation Services (IVRS), Iowa Medicaid Enterprise (IME), the Iowa Department on Aging (IDA), Iowa Department of Public Health (IDPH), The Department of Education (DE), Disability Rights Iowa (DRI), and The University of Iowa Center for Disabilities and Development (CDD). The Governor appoints all of these members.

The DD Council has an advocacy project called ID Action, which is focused on informing and mobilizing people with disabilities. Information can be found at IDAction.org. InfoNET is one of the Council's publications. InfoNET informs people on issues that affect people with disabilities, but does not take a stance on them. They publish stories periodically throughout the year on policy issues that affect people with disabilities. Brooke said they have seen growth in people coming to self-advocate. Individuals are meeting with legislators and articulating their wishes and needs. Issues lately have included voting, transportation, and accessibility issues. The transportation need is too great for public transportation to meet alone, and there is a need for more accessible resources for travel.

MHDS Update – Rick Shults and Theresa Armstrong
Theresa gave an update on the disaster behavioral health response efforts on the western side of the state and said Iowa has submitted a grant application to FEMA for mental health crisis and outreach counseling. Iowa was awarded an initial grant for 30 days and DHS is working with the CMHCs in the impacted area as well as ISU for the Iowa concern hotline. DHS will be submitting an application for a nine month grant to continue mental health outreach and counseling. Theresa gave an update on the eastern side of the state and said DHS is working with Vera French in seeing how many people have been affected and if the community can manage what is happening.

Rick gave an update on how the flooding made the water undrinkable at Glenwood Resource Center. Rick said the staff at Glenwood worked closely with the staff at Woodward Resource Center in moving 80 residents from Glenwood to Woodward. Staff from Glenwood volunteered to move to Woodward to help with staffing and provide care for the residents. Rick said the residents and staff were there for seven days until people from neighboring towns trucked in water to Glenwood.

Theresa gave an update on legislation related to the children's mental health system and state board. The Governor has signed the bill which makes the regions the responsible local entity, gives DHS responsibility for administrative rules, and codifies the state board. There are a few membership differences for the state board but the state board has continued their work and have used committees to help align where they need to make decisions. Theresa said the state board had recommended universal screenings and there were questions on what that meant. Mid Iowa Health Foundation awarded DHS a grant to form an expert panel to look at universal screenings and make a recommendation to the state board. The panel's first meeting is May 16th and information will be on the website.

Theresa gave an update on the 24 hour crisis line. IDPH and DHS are working closely together to look at Your Life Iowa and will be incorporating children's mental health resources in building out the webpage and crisis line. Foundation 2 currently has the contract for Your Life Iowa and there is still work to be done to see if they can meet expectations. The regions will also be involved in looking at transitioning regional crisis lines and how mobile response will be deployed. Theresa said they are looking for a soft start date of July 1.

There was discussion on the appropriations bill and how the money appropriated to the SCL ID Waiver tiers is exclusively for the ID Waiver and does not include the mental health tiers. Medicaid has had discussions on the habilitation tiered rates.

Regional Dashboards – Rose Kim

Rose Kim from MHDS introduced herself and presented the regional dashboards on where the MHDS Regions are at in implementing services including the new complex needs services.

There was discussion on how any major changes in the data from the previous report are due to changes in how the regions report their data. There was discussion on how many things are included under community supports that aren't Medicaid funded like rent support. There was discussion on the new core services and how the regions are in the implementation process and are just starting to meet access standards. These services look different than the other core services because the regions are developing the services.

There was discussion on ACT rates and how the appropriation amount to increase the rates started at 1 million and ended up at $211,000. There was discussion on how this amount does not match the amount identified in the report submitted to the legislature on ACT reimbursement rates. There was discussion on Youth ACT and how it is not developed as a fidelity model.

Legislative Panel – Senator Pam Jochum and Senator Zach Wahls

Senator Pam Jochum who serves on the MHDS Commission and Senator Zach Wahls a member of the MHPC introduced themselves and thanked the two groups for the work they do in advocating for those who are unable to advocate for themselves.

Senator Jochum said that she services on the human resource committee and encouraged the two groups to continue using their voice in government. Senator Jochum said the budget this year is less than it was the previous year and that is partly due to a supplemental appropriation made this year to fulfill the state's obligation made during negotiations with the MCOs. Senator

Jochum said there was disappointment this year in the lack of action taken to hold MCOs accountable and she had an amendment to carve out LTSS as well as there being other amendments that would've held MCOs accountable but they weren't considered due to a parliamentary producer being used to take them out.

Senator Wahls said that he completed his first session and was on education committees but has heard frustrations from across the state about mental health and disability services. Senator Wahls said that he has talked with another legislator about MCOs and the other legislator talked about how funding for services prior to MCOs was unsustainable. There was discussion about the cost of services and how focusing on prevention services could decrease the overall cost of services.

There was discussion about the idea of moving mental health services from the Department of Human Services to the Department of Public Health and the issue being around Medicaid. Rick Shults said that part of the success in moving the mental health system along is due to the close relationship between the mental health policy division and Medicaid. Rick said that his staff work closely with Medicaid staff and they are able to do that because they are under the same state agency. There was discussion about how the two state departments work closely together and have a strong working relationship. There was discussion about how the departments are to come up with a five year plan on working together regarding co-occurring conditions.

There was discussion about the importance of keeping the focus centered around the well-being of people and not focusing solely on the dollar amount. There was discussion about the need for coordinated public education on the mental health system and it should be a grass roots effort so the public can then put more pressure on the elected officials to focus on mental health in the state.

Public Comment
There was no public comment

The meeting was adjourned at 4:13 pm.

Minutes respectfully submitted by Julie Maas.

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL
March 20, 2019 10:00 am to 3:00 pm
Polk County River Place, Room 1
2309 Euclid Ave, Des Moines, IA
MEETING MINUTES

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL MEMBERS PRESENT:

Teresa Bomhoff
Kenneth Briggs Jr.
Jim Chesnik
Jim Cornick
Barb Anderson for Jim Donoghue
George Estle (phone)
Kathleen Goines (phone)
Gary Keller
Earl Kelly
Sharon Lambert (phone)
Todd Lange (phone)
Brenda Lechner
Julie Kalambokidis
LeAnn Moskowitz (phone)
Nathan Nash
Donna Richard-Langer
Brad Richardson (phone)
Lee Ann Russo
Dennis Sharp
Rosie Thierer
Heather Thomas
Michele Tilotta
Kimberly Wilson

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL MEMBERS ABSENT:
Kris Graves
Michael Kaufmann
Anna Killpack
Harry Olmstead
Carole Police
Jim Rixner
Jennifer Vitko

YOUTH CONSULTANT:
Justen Nash

OTHER ATTENDEES:

Theresa Armstrong	DHS, MHDS, Community Services & Planning
Connie Fanselow	DHS, MHDS, Community Services & Planning
Julie Maas	DHS, MHDS, Community Services & Planning
Annie Uetz	Polk County Health Services
Nastassia Walsh	National Association of Counties
Beth Manly	Iowa State Association of Counties
Jeanine Scott	Iowa State Association of Counties

Welcome and Call to Order
Teresa Bomhoff called the meeting to order at 10:02 a.m. and led introductions.

Committee and Workgroup Reports
Public Safety
The public safety workgroup had arranged a presentation on the Stepping Up Initiative which is a national initiative to reduce the number of people with mental illnesses in jail.

Nastassia Walsh, Program Manager at National Assn of Counties in Washington, DC; Annie Uetz, Polk Co. Health Services; and Jeanine Scott, IT and CSN (Community Services Network) Coordinator for ISAC introduced themselves and thanked the Council for inviting them to present. They presented their power point on the initiative. Nastassia shared the link to an online resource tool kit: www.stepuptogether.org/toolkit.

Minutes Approval
Quorum was established with sixteen members present and six participating by phone. Jim Rixner made a motion to approve the November meeting minutes. Brenda Lechner seconded the motion. The motion passed unanimously.

Nathan Nash made a motion to recruit two more youth consultants, ages 14 to 21. Jim Chesnik seconded the motion. The motion passed unanimously.

Committee and Workgroup Reports Continued
Monitoring and Oversight Committee
Donna Richard-Langer said the committee met before the January meeting and again today. The committee has been looking at the University of Iowa CDD contract and the contract for peer support training. Donna said they met with Karen Hyatt to review the peer support contract. Donna said the committee learned a lot of the people who are taking peer support training already have a job as a peer support specialist and they go through screening interviews to make sure they are at a good point to do the intensive training and work prior to enrolling in the training. Donna said that for most people attending the training their employer is paying for the training. Karen indicated that they are working on educating regions and providers to increase peer employment and some voice reluctance because they don't know how they will be reimbursed. There was discussion on reimbursement for peer support services. Donna said the committee asked Karen to provide information on what is being done to address employment barriers. There was discussion on how workforce is being addressed in other areas.

The Council broke for lunch at 12:10 pm and reconvened at 1:01 pm.

Committee and Workgroup Reports Continued
Outreach and Marketing Workgroup
Rosie Thierer said that they received the new member paperwork and are in the process of reviewing it. Rosie passed around a draft brochure and asked for input. The brochure will be used as a way to pass out information about the Council. There was discussion about how business cards would be beneficial.

Block Grant Committee
Teresa Bomhoff gave an update on HSB246 which is the block grant bill. The bill says the funding must still be split evenly between children and adults, there is no reference to federal requirements, and no guidance on how the 25% is spent. Teresa said the bill directs the remaining 70% to go to the regions instead of the CMHCs which is how it is currently. Teresa said that she registered the Council as undecided because there could still be

changes to the bill and she didn't think the Council wanted to pick a side between regions and CMHCs.

Teresa Bomhoff said the committee had a meeting with Laura Larkin to review the block grant application and only two of the committee members attended the meeting. Teresa said they discussed using charts in the application and to include that the Council was not represented on the Children's Board or on legislative workgroups. Teresa said that they reviewed part of the application and a lot of the work will be updating information. Teresa asked how the CMHCs will be impacted with the possible change of regions receiving the block grant. Theresa Armstrong said right now the priorities are individuals with the most complex needs and children and we are to use block grant dollars to fund priorities. Theresa said SAMHSA wants the money to be used for services and evidence based practices. There was discussion about the money being directed to the CMHCs or the regions and groups that are for and against the change. There was discussion about the substance use disorder block grant and how that money is distributed. There was discussion on if the Council wanted to register for or against HSB246.

Early Kelly made a motion to vote on if the Council should register a position on HSB246. Julie Kalambokidis seconded the motion. The following Council members abstained: Jim Cornick, Barb Anderson, LeAnn Moskowitz, Lee Ann Russo, Rosie Thierer, Michele Tilotta, and Kim Wilson. The following Council members voted in favor of voting: Ken Briggs, Kathleen Goines, Sharon Lambert, Brad Richardson, and Dennis Sharp. The following Council members voted against voting: Julie Kalambokidis, Gary Keller, Earl Kelly, Brenda Lechner, Nathan Nash, Donna Richard-Langer, and Heather Thomas. The motion to vote on if the Council should register a position on HSB246 did not pass.

Children's Workgroup

Nathan Nash said that he submitted a request to IDPH for information related to EPSDT screenings. Michele Tilotta said that she had forwarded the request to Director Clabaugh and will send out that information when it is compiled. Nathan said the children's bill (HF690) centers around the Children's Board structure and the regional governance going to the MHDS regions. There was discussion about the regions caring a heavy load and filling in the gaps for what Medicaid doesn't fund. There was discussion about requesting the Council be added to the State Board membership.

DHS Report

Theresa Armstrong gave an update on the Universal Screening Panel which is a subcommittee of the Children's Board. Theresa said DHS is using the grant from Mid Iowa Health Foundation to hire a facilitator to lead a group of experts in forming a recommendation for implementing universal screenings in Iowa. Theresa said HF690 lays out the State Board membership and responsibilities as well as the regions responsibility for developing access to a core set of services and adding individuals including a parent of a child with a serious emotion disturbance, an adult receiving services, and a representative from the school system as voting members. The Board will also add a children's advisory committee and a children's provider as a non-voting member. Theresa said the Children's State Board will meet on April 1 from 9:30am-12:30pm.

Theresa gave an update on disaster relief. Theresa said that Karen Hyatt has been heading up the disaster relief and volunteers have been called out to Freemont and Mills counties with 53 individuals receiving assistance. Theresa said the Governor has called for more assistance and they are looking to send out more teams.

Theresa said the regions have their annual budget and service plans due on April 1st and will be posted online. Theresa said the dashboards will be presented at the joint meeting in May. Theresa said Lyon County will be joining Sioux Rivers on July 1st and Woodbury will be joining Rolling Hills. Theresa said that during the previous session there was legislation allowing counties from CSS to form their own region within certain guidelines. Those counties did not meet the February 1st deadline. Kossuth, Winnebago, and Worth had already withdrawn from CSS and sent DHS a letter stating they had no other choices and asked DHS to assign them to a region. DHS assigned the counties back to CSS.

Theresa gave an update on the following legislation:

- HF296 is related to enrollment for a HCBS waiver and requires a prescreening done so that individuals would be eligible for waiver when assigned a slot.
- HF540 removes the monthly BI waiver cap.
- HF532 is related to residencies and gives priorities to Iowa residents and includes an opportunity for a rural residency.
- HF624 is related to inpatient bed tracking system and calls for a workgroup to look at improvements to current inpatient tracking.
- SF395 is related to the integrated provider network which is a SUD provider type and for Medicaid to match the CMHC reimbursement for that provider type.
- HF726 combines and eliminates boards. The Risk Pool Board from DHS is being eliminated.
- SF270 adds mental health awareness and prevention to curriculum for 7-12 grades.
- HF623 directs DHS to adopt rules allowing certain medications used for Medicaid Assisted Treatment to be available without prior authorization.
- SF538 calls for work requirements for Medicaid Iowa Health and Wellness program with exceptions for pregnant women and women with kids under certain age or medically except.

Teresa Bomhoff said that she registered the Council as against SF538. There was discussion about the negative impacts of this bill for individuals and the high administrative cost of work requirements.

Public Comment
None

Meeting adjourned at 3:30 pm

Meeting minutes respectfully submitted by Julie Maas

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL
May 15, 2019 10:00 am to 11:30am
Polk County River Place, Room 1
2309 Euclid Ave, Des Moines, IA
MEETING MINUTES

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL MEMBERS PRESENT:

Teresa Bomhoff
Kenneth Briggs Jr.
Jim Chesnik (phone)
Jim Cornick
George Estle
Kathleen Goines (phone)
Michael Kaufmann
Gary Keller
Earl Kelly
Anna Killpack
Todd Lange (phone)
Brenda Lechner (phone)
LeAnn Moskowitz
Nathan Nash
Carole Police
Donna Richard-Langer
Brad Richardson (phone)
Jennifer Robbins
Lee Ann Russo
Dennis Sharp
Rosie Thierer
Michele Tilotta
Kimberly Wilson (phone)
Senator Zach Wahls

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL MEMBERS ABSENT:

Harry Olmstead
Heather Thomas
Jim Rixner
Jim Donoghue
Julie Kalambokidis
Kris Graves
Sharon Lambert

YOUTH CONSULTANT:
Justen Nash

OTHER ATTENDEES:

Theresa Armstrong	DHS, MHDS, Community Services & Planning
Julie Maas	DHS, MHDS, Community Services & Planning

Welcome and Call to Order
Teresa Bomhoff called the meeting to order at 10:04 a.m. and led introductions. Quorum was established with seventeen members present in person and six member present by phone. Nathan Nash made a motion to approve the March 20, 2019 meeting minutes. Michael Kauffman seconded the motion. The motion to approve the March 20, 2019 minutes passed unanimously.

Committee and Workgroup Reports
Nominations Committee
The Council has two vacancies both for parents of children with a serious emotional disturbance. The committee has not received any applications for that category.

Monitoring and Oversight Committee
Donna Richard-Langer reported the committee met with Laura Larkin from MHDS to review the four Systems of Care contracts. Laura reviewed with the committee the counties that each program serves and how their funding works. Donna said the committee questioned if a per member per month was necessary or if each program should be allocated the same amount. Donna said that if any agencies would want to become a SOC program they would have to go to the legislature for funding.

There was discussion on how the SOC programs are funded with appropriations and Block Grant dollars. Theresa Armstrong said there is an appropriation in the legislature for each SOC program and it is an area that DHS can use surplus dollars from the Block Grant. Theresa said there are some Block Grant contracts that don't expend all their dollars and DHS tries to adequately use federal dollars before using state dollars. Theresa said that DHS is allowed to move money within certain funds and ensures that all funds are used appropriately.

There was discussion on why a CMHC might not use all of their allocated money such as trainings not being able to happen as quickly as planned or a CMHC might choose not to use all their dollars. Theresa said there are 26 CMHCs that contract for Block Grant dollars and that money can add up. Theresa said that throughout the year all Block Grant contracts are reviewed to see how they are spending their dollars and that's when DHS starts using federal funds for current programs.

Public Safety Committee
The public safety committee invited Sheriff Jason Sandholdt to speak to the Council about the role law enforcement's role in the mental health system and their priorities. Sheriff Sandholdt said one of the roles law enforcement and sheriffs in particular play is in transporting individuals to the hospital. Sheriff Sandholdt said that law enforcement was concerned about how far individuals had to go from their homes to receive the treatment they need and access centers are a good option for individuals receiving the necessary treatment and staying closer to home. Sheriff Sandholdt said that law enforcement hopes to see this repeated with the children's system.

There was discussion on how different aspects of the access centers would work i.e. transportation, medical clearance, and working with the judicial system. It was discussed how it could be different depending on how the access center is set up and there will be a learning curve for everyone involved. There was discussion on how access centers are just one piece of an array of services and mobile crisis will most likely play a big role with access centers.

Public Comment
None

The Council broke for lunch at 11:50am and reconvened with the MHDS Commission at 12:31pm.

Meeting minutes respectfully submitted by Julie Maas

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Teresa Bomhoff	Family Members of Individuals in Recovery (to include family members of adults with SMI)		200 SW 42nd St. Des Moines IA, 50312 PH: 515-274-6876	tbomhoff@mchsi.com
Ken Briggs	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1701 Campus Drive Clive IA, 50325 PH: 515-221-4560	revkbriggsacc@msn.com
Jim Chesnik	State Employees	Iowa Department of Human Services		
Jim Cornick	Others (Advocates who are not State employees or providers)		624 Glenview Drive Des Moines IA, 50312 PH: 515-255-4932	jcornick65@gmail.com
Jim Donoghue	State Employees	Iowa Department of Education	400 E. 14th St. Des Moines IA, 50319 PH: 515-581-8505	jim.donoghue@iowa.gov
George Estle	Others (Advocates who are not State employees or providers)		3163 Westview Drive NE Solon IA, 52333 PH: 319-360-9468	george.estle@gmail.com
Kathleen Goins	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		129 West High Street Villisca IA, 50864 PH: 712-542-0018	Kathleen@waubonsiemhc.com
Julie Kalambokidis	Parents of children with SED/SUD		18 1/2 N. Walnut St. Glenwood IA, 51534 PH: 712-527-4188	JKalambokidis@EmbraceIowaInc.com
Michael Kauffman	State Employees	Iowa Department of Human Services	Independence MHI Independence IA, 50644 PH: 319-334-2583	MKaufma@dhs.state.ia.us
Gary Keller	State Employees	Iowa Department of Corrections	Iowa Medical and Classification Center Oakdale IA, PH: 515-725-5289	gary.j.keller@iowa.gove
Earl Kelly	Others (Advocates who are not State employees or providers)		2919 Druid Hill Drive Des Moines IA, 50315 PH: 515-288-9646	earlpkelly@gmail.com

Anna Killpack	Parents of children with SED/SUD		32356 270th St. Neola IA, 51559 PH: 712-485-2016	annakillpack@yahoo.com
Todd Lange	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		225 W. 6th St. Dubuque IA, 52001 PH: 563-564-2933	Tjlange1@yahoo.com
Brenda Lechner	Parents of children with SED/SUD		406 7th St. West Des Moines IA, 50265 PH: 515-343-6699	brendajlechner@gmail.com
LeAnn Moskowitz	State Employees	Iowa DHS, Iowa Medicaid Enterprise	611 5th Ave. Des Moines IA, 50309 PH: 515-256-4653	lmoskow@dhs.state.ia.us
Justen Nash	Youth/adolescent representative (or member from an organization serving young people)		3115 Avenue I Fort Madison IA, 52627	
Nathan Nash	Parents of children with SED/SUD		3115 Avenue I Fort Madison IA, 52627 PH: 319-371-1698	Nathannash4@mchsi.com
Carole Anne Police	Family Members of Individuals in Recovery (to include family members of adults with SMI)		104 3rd St. Apt. 6 Neola IA, 51559 PH: 712-485-2016	carolepolice@icloud.com
Donna Richard-Langer	Others (Advocates who are not State employees or providers)		4105 Belair Drive Urbandale IA, 50323 PH: 515-278-7010	drldkl@msn.com
Brad Richardson	State Employees		UI School of Social Work Iowa City IA, 52242-5000 PH: 515-953-1990	Brad-richardson@uiowa.edu
James Rixner	Family Members of Individuals in Recovery (to include family members of adults with SMI)		114 Midvale Avenue Sioux City IA, 51104 PH: 712-258-7855	jwrx@aol.com
Jennifer Robbins	Others (Advocates who are not State employees or providers)		102 E. Main St. Box 217 Ottumwa IA, 52501 PH: 641-683-4576	jennifer.robbins@scbhr.net
LeeAnn Russo	State Employees	Vocational Rehabilitation	510 E. 12th St. Des Moines IA, 50319 PH: 319-290-4526	leeann.russo@iowa.gov
Melissa Schwery	Parents of children with SED/SUD		1302 Hawkeye Ave, Apt C-5 Harlan IA, 51537 PH: 712-404-0526	Bmschwery3@gmail.com
Dennis Sharp	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1104 River Drive South Apt. 10 Sioux City IA, 51104 PH: 712-899-2809	dennissharp2007@gmail.com
Michael Straight	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		129 West High St. Villisca IA, 50864 PH: 402-874-0277	Mistraight61@gmail.com
Rosie Thierer	State Employees	Iowa Department on Aging		
Heather Thomas	Providers	Eyerly Ball Community Mental Health Center	PH: 515-729-3736	HeatherT@eyerlyball.org

Michele Tilotta	Persons in recovery from or providing treatment for or advocating for SUD services	Iowa Department of Health		michele.tilotta@idph.iowa.gov
Heather Wellman	Parents of children with SED/SUD		46 Oak Drive Fort Madison IA, 52627 PH: 319-371-7768	heather@welllman.fm
Brook Whitney	State Employees	Iowa Finance Authority	State Housing Authority	Brook.Whitney@IowaFinance.com
Kimberly Wilson	Others (Advocates who are not State employees or providers)		2510 320th St. Spencer IA, 51301 PH: 712-262-9438	kwilson@co.clay.ia.us

*Council members should be listed only once by type of membership and Agency/organization represented.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

The State Social Services Agency representative Jim Chesnik is retiring, a new representative is in the process of being chosen.
Other State Agency representatives-
Jim Donoghue-State Education Agency
Michael Kauffman-State Mental Health Agency
Gary Keller-State Criminal Justice Agency
Lee Ann Moskowitz-State Health Agency
Lee Ann Russo-State Vocational Rehabilitation Agency
Brook Whitney-State Housing Agency

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**33**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	4	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	4	
Parents of children with SED/SUD*	6	
Vacancies (Individuals and Family Members)	2	
Others (Advocates who are not State employees or providers)	6	
Persons in recovery from or providing treatment for or advocating for SUD services	1	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**23**	**69.70%**
State Employees	9	
Providers	1	
Vacancies	0	
Total State Employees & Providers	**10**	**30.30%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	1	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a)	Public meetings or hearings?	○ Yes ◉ No
b)	Posting of the plan on the web for public comment?	◉ Yes ○ No
	If yes, provide URL: https://dhs.iowa.gov/mhds-providers/providers-regions/block-grant	
c)	Other (e.g. public service announcements, print media)	○ Yes ◉ No

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

8-25-19 - Chairperson Teresa Bomhoff Review of 2019-2020 Draft MHBG Application and suggestions for improvement – 5 pages **1 of 5**

Page 12

Step 1 - Address the strengths and organizational capacity of the service system to address the specific populations

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

Table of Contents:

Page numbers indicated in the following chart are from the MHBG application on the lower right hand of the page.

These are SUGGESTIONS.

	T. Bomhoff Comment		DHS-MHDS Response:
Page 15	Under Iowa Dept of Education In 2018, legislation was passed that required all public school districts to provide 1 hour of school employee training regarding suicide prevention and postvention, identification of adverse childhood experiences and strategies to mitigate toxic.....		Correction made in plan.
Page 18	Prior to E. LEGISLATION AFFECTING THE PUBLIC MENTAL HEALTH SYSTEM – insert the following statement: "A chart of Regional Services for both adults and children is provided at Page _____ of the application." Attached to this review document is a proposed chart.		The chart is not a DHS product and has not been vetted, therefore will not be included as part of the plan. It will be included as part of the comment document.
Page 20	Put a space between the first and second paragraph. In the 2nd paragraph, switch the 2 sentences so the 2nd sentence is first, etc. The new 2nd sentence of the 2nd paragraph should be ended at the colon. Instead of using bullets – state the domain name and then the corresponding sentence (previously bulleted) For ex: Access to services Individuals with disabilities and mental illnesses have timely. . . . . . To separate the last paragraph on the page - Insert a space before it.	The IMHPC has not seen the current finished Olmstead Plan yet.	Changes in spacing and order of sentences made. The changes requested to list of Olmstead domains was not made.
Page 24	Suicide – the suicide rate in Iowa increased by 36% since the year 2000 according to the CDC.		Statistic added to plan.
Page 25-26	Put charts on the page 1 at a time rather than 2 side-by-side. It will increase the size of the script and be easier to decipher. Bottom of page 26 under Crisis Intervention team – please put a space between the paragraphs to separate them.		This was reformatted as suggested.
Page 31	Specialized units in general hospitals #'s of beds – Iowa Lutheran closed 16 adult beds around two weeks ago – said it was temporary – for repairs and because they have a workforce shortage. We'll see whether it remains temporary. Are the additional inpatient beds in Mason City completed? It would add 12 beds? Is the new psychiatric hospital in SE Iowa completed? It would add 72		DHS has no information on capacity changes at Iowa Lutheran. DHS has no information about additional beds added in Mason City. The new psychiatric inpatient hospital in Bettendorf is under construction and is expected to open in late

	T. Bomhoff Comment		DHS-MHDS Response:
	beds? I don't have the breakdown of beds for # adult, # kids, # geriatric when they are complete. State the inpatient units in hospitals have significant issues with boarding of MH patients in the ER's for hours and days at a time. (comment added) MHI's – please indicate whether they have waiting lists?		January-early February 2020. The comment about boarding in ERs has been added to the plan. MHIs maintain waiting lists when necessary. This changes on a daily basis.
Page 32	Insert how many residential facilities and beds have been closed down in the last 5-10 years to facilitate more people moving to more community-based care. Insert how many intermediate care facilities and beds have been closed down in the last 5-10 years to facilitate more people moving to more community-based care. PMIC's Separate this sentence and make it a paragraph of its own. *Iowa also utilizes out of state PMIC/PRTF facilities for children who are not able to be served within the state of Iowa. (Change made)* Insert how many people are in out-of-state care? # kids and # adults, too?	Attached is a geriatric patient housing review report which includes a DHS/MHDS vacant building list. Link to report here: https://www.legis.iowa.gov/docs/publications/DF/1022677.pdf	The geriatric patient housing review referenced here includes a list of RCFs that have closed from 2006-2018. It is not possible to identify how many have closed for the reason of moving people to community-based care. DHS has no information on any recent ICF-PMI facilities that have closed. DHS added information to the plan about numbers of Iowans served in out of state facilities.
Page 39	2nd paragraph under MH professionals statewide: Listed are various MH professionals by # licensed – it would be an improved reflection to show this - _____ of 679 licensed psychologists are currently practicing. Each professional organization should be able to give you this information.		Information such as this would only be reflective of membership of each professional organization. Not all licensed mental health professionals belong to a professional organization. DHS did not add this information.
Page 40	Under Mental Health Professional Shortage areas: First sentence – lists 86 of 99 counties - Put the Primecare information in a separate paragraph – add how many mental health professionals were helped last year? Psych residency programs – add		DHS added additional information where available to the plan on the suggested additions to the mental health workforce section.

	T. Bomhoff Comment		DHS-MHDS Response:
	language and numbers for each program For ex: U. of Iowa - ___ graduates per year, how many stayed in Iowa last year? Broadlawns/Unitypoint/DM VA – 4 graduates per year – 1st graduates in 2022 Mercy – 4 graduates per year – 1st graduates in 2022 Additional residency money from 2019 state budget intended for more rural psychiatrists This language is repeated 3 times under children's mental health system *The Iowa system for children's mental health services also includes multiple agencies, within and outside of the Department of Human Services, each with their own eligibility, funding, and limitations for provision of mental health services. Available services are dependent on type of insurance and locality, as some areas may have a larger service array and more financial investment in children's mental health services.*		Duplicate information in the children's mental health system section was deleted.
Page 41	Middle of the page - there are more programs in IDPH than are listed: Statewide crisis line Health Care Safety Net Emergency &Trauma services Health Care Transformation Professional Licensure Health Statistics Substance Abuse Home Visiting Health Workforce Local Public Health Services First 5 Minority & Multicultural Health ACES and more Youth Suicide Prevention Direct Care Workforce Access to Quality Rural Health Services Adolescent Health Brain Injury Child Health Child Health Specialty Clinics Child Protection Centers Disability and Health Early Childhood Hawk-I Outreach		A more extensive list of IDPH programs was added to the plan.
Page 41 Page 42	In the paragraph starting with "Children in Need" – there is		Correction made in the plan.

	T. Bomhoff Comment		DHS-MHDS Response:
	considerable language on BHIS services. BHIS is also discussed at length on page 42. Suggest referencing BHIS services in "Children in Need" and referring them to a complete discussion of BHIS on Page 42.		
Page 42	Children's Mental Health Waiver Instead of explaining the numbers in paragraph form -- use a chart instead CMS Slot Cap: 1360 Reserved CMH Waivers: 10 # slots approved & in use: 966 Applications in process: 260 Waiting list: 1372		Chart added to plan as requested.
Pages 43	For school based mental health services – indicate the # of schools and school districts in Iowa. List the contractors who are providing the services? And how many schools each is operating in out of a total of ____ schools statewide? # of kids served out of total kids in schools across the state? Systems of Care -- how many kids served in current 4 programs?		School based information is not available at this time. SOC numbers served added to the plan.
Page 44	Foster Care/Transition age youth – indicate total kids in foster care and transition annually. Indicate how many kids currently served in SAL program annually. Indicate how many kids currently served in Aftercare annually.		Foster care, SAL, transition and aftercare data were added.
Page 45	Elderly waiver – indicate total served by waiver, how many applications in process and how many on the waiting list. PASSR – how many served annually in PASSR system?		Both items requested were added to the plan.
Page 47	Indicate how many homeless youth there are in Iowa How many homeless youth are helped with the PATH's $334,449 allocation? How many homeless youth are helped with the SOAR program? How many homeless youth are helped by the HCBS waiver rent subsidy program? How many people are served by the supported housing program in regions? With no numbers dividing into youth and adults served.		Indicate how many homeless youth there are in Iowa DHS response: How many homeless youth are helped with the PATH's $334,449 allocation? **DHS response : No youth under age 18 were served, PATH is limited to adults.** How many homeless youth are helped with the SOAR program? **DHS Response: SOAR recently started training for completing children's SSI applications. No one from IA has completed the training.**

	T. Bomhoff Comment		DHS-MHDS Response:
			How many homeless youth are helped by the HCBS waiver rent subsidy program? **DHS response: The program is not available to persons under the age of 18.** How many people are served by the supported housing program in regions? With no numbers dividing into youth and adults served. **DHS response: Regional data regarding persons served is not complete as some regions block grant these programs. In SFY18, regions spent $3,995,462 on supported housing.**
Page 50	**Planning Steps - Step 2: Identify the unmet service needs and critical gaps within the current system.**		
	This step should identify the unmet service needs and critical gaps in its current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority. The step should also address how the state plans to meet the unmet service needs and gaps.		
Page 51	SOC programs for non-Medicaid eligible children remain limited to 14 of 99 counties in Iowa.		Change made.
Page 52	Iowa Youth Survey - 10.1% or 7122 students of all students surveyed		DHS did not make this change as the Iowa Youth Survey did not identify the exact number, just the percentage who answered that question.
Page 53	IMHPC - Needs and Concerns of *Overall Mental Health system* – add: Inadequate funding – too low Medicaid reimbursement rates, frozen county mental health levies since 1996, and lack of mental health parity enforcement. Add to Suicide entry – the state suicide rate has increased 36% since 2000 IMHPC – Needs and Concerns of *Children with an SED* – add: Revise Children's crisis services statement to:		Changes made as requested.

	T. Bomhoff Comment		DHS-MHDS Response:
	There is enthusiasm for the initial funding of children's mental health crisis services however there are no sources of adequate annual sustainable funding for long-term support for them at this time. There is a need for separate rooms in schools that would be designed to help children with mental health needs to calm down.		
Page 54	Of the items listed under Adults with SMI – the last two should be listed under "Children with an SED". *Training in the new Teen Mental Health First Aid model* *Financial support for new children's crisis services to be funded by the MHDS regions* Older Adults with SMI – at the 3rd bullet point – change to: *Concern over whether older adults in nursing facilities are medicated to treat their needs, or to make them easier to manage.* Rural and homeless – add: *Not enough affordable housing* *Not enough mental health practitioners*		Changes made as requested.
Page 55-58	Noting the IMHPC has not been advised, prior to this draft – of what the 3 priorities are.		
Page 59	I'm assuming the total of the MHBG grant $10,542,180 is for 2 years – both 2019 and 2020. Since the 2019 grant was for $5,377,612, it would make the 2020 grant $5,164,568 – has the 2020 grant amount been determined for sure? The entry for 8. Ambulatory/Community Non24 Hour Care is wrong – not all the money is used for that purpose – 25% or so is used for other contracts for differing purposes. However, there's no category in this chart where the 25% number would fit.		The 2020 amount has not been finalized, this is the projected amount provided by SAMHSA. For Line 8, there is not a line that completely describes the activities the MHBG funds are used for. This is also a projection, not actual funds expended.
Page 61	Table 6 – I don't understand where the numbers came from, nor what the activities are in: Infrastructure Support Partnerships, community outreach, and needs assessment Planning Council Activities (MHBG required, SABG optional), and Training and Education		See footnotes in Table 6 for explanations of each line.
Page 62-64	**Environmental Factors and Plan**		

		T. Bomhoff Comment		DHS-MHDS Response:
	1	The Health Care System, parity and integration – Question 1 and 2 are required 10 questions – the first two questions were answered, not questions 3-10. Why were the 8 questions not answered?		The state primarily focuses efforts on answering those sections which are required.
Page 66-67	2	Health Disparities – Requested None of the 7 questions were answered. Reason?		See answer to #1.
Page 68-69	3	Innovation in Purchasing Decisions – requested None of the 3 questions were answered. Reason?		See answer to #1.
Pages 70-71	4	Evidence Based Practices for Early Interventions to Address ESMI – 10% set aside – required MHBG All 10 questions answered – GREAT!		
Page 72	5	Person Centered Planning – required MHBG All 4 questions answered – GREAT!		
Page 73	6	Program Integrity – required MHBG All 3 questions answered – GREAT!		
Page 74	7	Tribes – requested None of the 3 questions answered – Reason?		See answer to #1.
		There is no item 8 in this section		
Page 75-81	9	Statutory Criterion for MHBG – required MHBG All 4 questions answered – GREAT! All 5 criterion answered and match the narrative – GREAT!		
		There is no item 10 in this section		
Page 82	11	Quality Improvement Plan – requested The 1 question not answered. Reason?		See answer to #1.
Page 83	12	Trauma – requested None of the 5 questions answered. Reason?		See answer to #1.
Page 84	13	Criminal and Juvenile Justice – requested None of the 5 questions answered. Reason?		See answer to #1.
		There is no item 14 in this section		
Page 85-86	15	Crisis Services – requested All 4 questions answered – GREAT!		
Page 87-88	16	Recovery – required All 5 questions answered – GREAT!		
Page 89	17	Community Living and Implementation of Olmstead None of the 3 questions were answered. Reason?		See answer to #1.
Page 90-	18	Children and Adolescents M/SUD Services – required MHBG		

		T. Bomhoff Comment		DHS-MHDS Response:
92		All 7 questions answered – GREAT!		
Page 93	19	Suicide Prevention – required MHBG All 5 questions were answered. Reason?		This was a required section.
Page 94	20	Support of State Partners – required for MHBG All 3 questions were answered. GREAT!		
Page 96	21	State Planning/Advisory Council and Input on MHBG application All 3 questions were answered. GREAT!		
		Attachments		
Pg. 97-128		IMHPC Bylaws 5-15-19 – Minutes of IMHPC meeting 5-14-19 – Minutes of MHDS meeting with MHPC Block Grant Committee 3-19-19 – Minutes of MHDS meeting with MHPC Block Grant Committee 3-20-19 – Minutes of IMHPC meeting 5-15-18 – Minutes of IMHPC and MHDS Commission meeting 7-17-19 – Minutes of IMHPC meeting	Arrange in chronological order?	Staff attempted to reload the documents in chronological order but the system would not load them in that way.
Pages 130-161		**Should be removed since they are a duplication of pages 97-128**		This is a system generated error and was sent to SAMHSA for correction on 8/27.
		Environmental Factors and Plan		
Page 162-164		Advisory Council Members – *Start Year 2020 – End Year 2021* Instruction say to identify certain state agencies w/pertinent members Remove Jim Chesnik – he retires at the end of August 2019 <u>Under the column Agency or Organization Represented</u> Lee Ann Moskowitz – add "State Health Agency" Brook Whitney – add "State Housing Agency" Gary Keller – add "State Criminal Justice Agency" Lee Ann Russo – add "State Vocational Rehabilitation Agency" Jim Donoghue – add "State Education Agency"		See footnotes in this section for explanation of Jim Chesnik being listed, and a list of the required State Agency Reps. The system does not allow us to designate them as such when entering them in the system.
Page 165		Advisory Council Composition by Member Type – *Start Year 2020 – End Year 2021* 4 individuals in Recovery 4 family members of adults with SMI		This list is generated from the advisory council list on the previous table. I complete that list from the MHPC membership

	T. Bomhoff Comment		DHS-MHDS Response:
	6 parents of kids with SED 2 vacancies (individuals and family members) 4 others 3 persons advocating for SUD services 0 reps from Tribes 23 total 8 State employees 1 Provider 1 Vacancy 10 total Grand total is 33 members		list. I cannot change this table as the categories are driven by the role the member is listed in on the previous page. Individuals can only fulfill one role. If someone's primary role should be changed to "persons in recovery from or providing treatment for or advocating for SUD services" , let DHS know. Currently, the IDPH rep is the only person designated for that role.
Page 166	Public Comment – all questions answered		

Iowa Mental Health Regional Services and Supports Grid

Information taken from 5-13-19 Iowa Dept. of Human Services Statewide Report SFY 2018 and HF 690.

Mental Health and Disability Services Regions fund services for residents who meet diagnostic and financial eligibility requirements. This grid provides the details of the Services by Diagnosis charts. All services can be designated into one of **three categories**:

1. **Community living supports (supplemental services)** are those services that Regions are not required to fund, but choose to fund for eligible residents of their region. Supports may not meet "medical necessity" criteria but are critical to a person's well-being and life in a community. It also includes the mental health commitment costs Iowa Code mandates Regions to fund.

2. **Core services** are the services regions are required by Iowa Code to fund; and

3. **Additional Core Services** are services identified in Iowa Code that Regions are to fund when public funds are made available for such services.

The **types of services** can be identified as:

- Community and Coordination Services
- Housing and Community Living Supports
- Treatment Services; and
- Vocational and Day Services

Children's behavioral health services provided to eligible children that are not covered under the medical assistance program or other third-party payor are the responsibility of the county-based regional service system.

Core Domain - Treatment designed to ameliorate a child's serious emotional disturbance,
Core Domain - Comprehensive facility and community-based crisis services regardless of a diagnosis of a serious emotional disturbance
Additional Core Domain - Treatment designed to ameliorate a child's serious emotional disturbance including but not limited to behavioral health school-based therapy
Additional Core Domain - Support for community living
Additional Core Domain - Transition services for children to the adult mental health system providing an appropriate match with a child's abilities based upon informed, person-centered choices made from an array of options
Additional Core Domain - Service coordination including physical health and primary care that follow the principles of the system of care

Regional Services	Regional $'s ADULT Community Living Supports	Medicaid eligible Adult Mandated Core Services	Medicaid eligible Children's Mandated Core Services – HF 690	Medicaid eligible Adult Additional Core Services	Medicaid eligible Children's Additional Core Services – HF 690
Community and Coordination Services					
Information & referral, Consultation and Public education	X				
Prevention, early identification, early intervention, and education			HF690 331.397A 4a2		
Provider Education for Evidence Based Practices		X			
Case Management or Health Home coordination		X			HF690-331.397A 4d2
Care Coordination					HF690-331.397A 4d1
Service Management	X				
Crisis Coordination Services	X				
Justice System Involved Coordination Services and Mental Health Court				X	
Crisis Prevention Training				X	
Housing and Community Living Supports					
Academic Services	X				
Transportation	X				
Home Health Aides		X			
Chore Services	X				
Personal Emergency Response		X			
Respite Services		X			HF690 –331.397A 5b4
Guardian/Conservator/Payee	X				
Home/ Vehicle Modification		X			
Supported Community Living		X			
Consumer Directed Attendant Care	X				
Supportive Housing		X			
Food, Rent, Utilities, and/or Basic Needs	X				
Family and Peer Support Services and Family Psychoeducation		X			HF690-331.397A 5b1,2
Subacute Services		HF 2456			
Residential Care Facilities	X				
Intermediate Care Facilities & State Resource Centers	X				
Access Centers		HF 2456			
Therapeutic Foster Care					HF690-331.397A 5b3

Regional Services	Regional $'s ADULT Community Living Supports	Medicaid eligible Adult Mandated Core Services	Medicaid eligible Children's Mandated Core Services – HF 690	Medicaid eligible Adult Additional Core Services	Medicaid eligible Children's Additional Core Services – HF 690
Treatment Services					
Physiological Treatment: Outpatient, In-Home Nursing & Health Supplies	X				
Prescription Medication	X				
Psychotherapeutic-Outpatient, and Medication Prescribing & Management		X	HF690-331.397A 4a3 and 4a4		
Partial Hospitalization	X				
Behavioral Health School Based Therapy					HF690-331.397A 5a
Transitional Living Program	X				
Day Treatment Services	X				
Peer Self-help Drop-in Center				X	
Community Support Programs	X				
Psychiatric Rehabilitation				X	
Assertive Community Treatment (ACT)		HF 2456			
Assessment and Evaluation (non-crisis)		X	HF690-331.397A 4a2		
Inpatient treatment		X	HF690-331.397A 4b4		
Crisis Evaluation		X			
Emergency Medical Care	X				
24-hour Crisis Response Services		X			
Mobile Response, 23-hour Observation & Crisis Stabilization Services		HF 2456	HF690-331.397A 4b1, 4b2, 4b3		
24-hour Crisis Line & Warm Line		HF 2456			
Mental Health Services in Jails				X	
Iowa Medical & Classification Center*	X				
Commitment Services*	X				
Prescreening Evaluation				X	
Intensive Residential Service Homes		HF 2456			
Vocational and Day Services					
Vocational Skills Training, Supportive Education & Sheltered Work	X				HF690-331.397A 4c5
Prevocational Services		X			HF690-331.397A 4c4
Day Habilitation		X			HF690-331.397A 4c1
Job Development & Supported Employment		X			HF690-331.397A 4c2,3

*Mandated commitment costs

From: Maas, Julie
Sent: Monday, August 26, 2019 10:08 AM
To: Larkin, Laura
Subject: FW: FW: 2020-21 MHBG Plan for review and comment-comments due to Laura Larkin by Mon. Aug. 26 at 10am

From: Donoghue, Jim <jim.donoghue@iowa.gov>
Sent: Monday, August 26, 2019 10:01 AM
To: Maas, Julie <jmaas@dhs.state.ia.us>
Subject: Re: FW: 2020-21 MHBG Plan for review and comment-comments due to Laura Larkin by Mon. Aug. 26 at 10am

Laura,

As in the past I learned new stuff reading through the draft.
It is excellent.
I have only 2 thoughts.

p.39 top 2nd sentence list of services from CMHCs. List does not include psychiatric or medication management. Is that not required of a CMHC? or is the issue that not all CMHCs have such.

MHDS Response: The services listed on P. 39 are the categories of services that DHS accredits under Chapter 24, not the comprehensive list of the services that CMHCs are required to provide. Those services are listed in Iowa Code Chapter 230A and include psychiatry and medication management. This is from Iowa Code Chapter 230A.106 (2). a.

a. Outpatient services. Outpatient services shall consist of evaluation and treatment services provided on an ambulatory basis for the target population. Outpatient services include psychiatric evaluations, medication management, and individual, family, and group therapy. In addition, outpatient services shall include specialized outpatient services directed to the following segments of the target population: children, elderly, individuals who have serious and persistent mental illness, and residents of the service area who have been discharged from inpatient treatment at a mental health facility. Outpatient services shall provide elements of diagnosis, treatment, and appropriate follow-up. The provision of only screening and referral services does not constitute outpatient services.

p. 43 correct term is "Individual Education Program" not Plan.

MHDS Response: this was corrected in the final plan.

p. 43 correct term is "Local Education Agencies" not Local School Systems. You use the correct term on page 23

MHDS Response: this was corrected in the final plan.

Thank you for your work on this Jim

From: Donna Richard-Langer [mailto:drldkl@msn.com]
Sent: Tuesday, August 27, 2019 8:40 PM
To: Larkin, Laura
Subject: Fw: 2019-2021 MHBG Draft Report Comments and Suggestions

Laura, you did another amazing job with the Block Grant Application. This is an incredible document and gives such a good overview of what is happening in our state. I know that we were to get our responses and suggestions in by yesterday and I apologize.
I have a few comments and I have a few typos.

typos:
p. 37 first paragraph 3rd sentence. Eliminate the word "obtain" or "get' in the sentence that starts "The purpose of intensive psychiatric rehab services.....

MHDS Response: This was corrected in the plan.

p. 40 the second last paragraph. The second sentence and the last sentence in that paragraph are the same.

MHDS Response: This was corrected in the plan.

Are the MHPC By-Laws included twice at the end?

MHDS response: This is a system-generated error which SAMHSA has been made aware of.

p. 21 I didn't remember that MHDS asked the MHPC for consultation on the Olmstead Plan. We did receive a copy.

MHDS response: DHS staff Connie Fanselow did a presentation to the planning council. The intent of the presentation was to share the Olmstead plan with the planning council as well as get any feedback from the council on the plan.

p. 28 I would have to express my concern that the MCO's have not provided high quality healthcare appropriate to a member's health and functional status. The council has received complaints from people that have not received the services that they need. In addition, provider agencies have continued to report that they are not paid in a timely fashion from the MCO's.

MHDS response: This comment was added to Step 2: Planning Council needs and concerns

I also wonder about the connection between the goals that are set in the Block Grant for the upcoming year(s) and the decisions made with regard to how the Block Grant funds will be allocated.

MHDS response: DHS attempts to set goals that are reflective of the needs of the mental health system of which the MHBG funding is a part.

Thank you for all of your hard work on this document.
Donna